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What to include in nursing handover

Health care is complex. The processes necessary for communicating health care information are a continuous challenge for health care professionals and health care institutions. Deficient communication processes create the potential for errors when caregivers fail to transfer complete, consistent information []. Clinical handovers are practiced every day, in many ways, in all institutional health care settings [,]. The clinical handover of patients, according to the Australian Council for Safety and Quality in Health Care's 2005 clinical handover report [], concerns and is defined as follows: the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. The literature distinguishes three basic types of good practice in nursing handover: bedside, verbal, and nonverbal. Handovers at the bedside promote face-to-face interaction between patients and nurses and encourage patients to participate verbally, thus putting them at the center of the information exchange process [,]. Verbal communication usually takes place in an office setting, where the nurse responsible for a group of patients describes relevant documented information and perhaps gives their professional opinion. Nonverbal communication also usually takes place in an office setting, where nurses inform themselves by reading patients' health records, including progress notes, medication charts, observation charts, and nursing care plans. Finally, recorded communication can also be used in an office setting if the nurse in charge makes a recording describing the relevant information so that the oncoming shift can listen to it at a convenient time. Deficient or absent clinical handovers, or failures to transfer information, responsibility, and accountability, can have severe consequences for hospitalized patients []. They have been shown to result in delays to diagnosis, treatment, and care; tests being missed or duplicated; and subsequent incorrect operationalization of care plans or drug follow-up []. More than a decade ago, the World Health Organization (WHO) collaborating centers in patient safety strongly recommended that their members improve communication during patient handovers by declaring the following: "Ensure that health-care organizations implement a standardized approach to handover communication between staff, change of shift and between different patient care units in the course of a patient transfer" []. Unfortunately, the world's countries were not universally proactive in addressing this recommendation and implementing structured, evidence-based handovers to improve patient safety and the continuity of care. Countries such as Australia, Belgium, China, Spain, the United Kingdom of Great Britain and Northern Ireland, the United States, and the Netherlands developed national and regional standards for nursing and interprofessional handovers [,]. Despite a recent systematic review by Bukoh and Siah, which demonstrated that structured handovers reduced incidences of patient complications, medication errors, and general adverse events, none of the handover standards examined had been designed using a robust evidence-based methodology. As a consequence of this lack of strong evidence, countries and health care institutions naturally hesitate to adopt standardized handovers. To the best of our knowledge, there are currently no national, regional, or local evidence-based nursing handover standards in use in Switzerland []. Although some Swiss university hospitals are working hard to implement more structured nursing handover systems, no national policy is available as yet. This research is a first step toward the development of a more widespread nursing standard of evidence-based handover communication. It will support the nursing experts who are declaring that patient safety will be improved by the implementation of care delivery systems that effectively structure handover communication []. Nursing handover practices in our multisite hospital in Switzerland were highly variable, sometimes unreliable, and differed across medical specialties. This led to inconsistencies in the content and accuracy of handover information. Preceding studies have revealed multiple barriers to communication within health care organizations, including hierarchy, gender, ethnic background, primary health care education, and different communication styles [,]. Inconsistencies in communication may cause substantial risks to patient safety and care []. Other health care institutions have recently tried to uncover the specific risks and contributing factors to difficulties in handover communications []. In 2017, an internal survey of health care professionals at a multisite public hospital in Switzerland, concerning its culture of patient care safety, revealed that almost two-thirds of them (ie, nurses, physicians, and allied health care professionals) considered the quality of information transmission to be deficient and a risk to the safety of their patients []. Intervention studies have shown that information is poorly preserved if verbal or handwritten handovers are transferred across multiple shifts [], rather like a game of broken telephone. Validated causes at the root of handover communication failures include institutional cultures that fail to promote effective handovers (eg, lack of teamwork and respect); the different expectations of information givers and receivers; inadequate methods of communication, whether verbal, recorded, bedside, or written; ill-timed or badly coordinated physical transfers and patient handovers; interruptions to, or the lack of time allocated to, successful handovers; nonstandardized handover procedures; insufficient staff to ensure effective handovers at pertinent times of the day or week; and a lack of participation by patients during their handovers [,]. The web-based, modified, electronic Delphi (e-Delphi) survey presented here developed standardized solutions to these risks and then developed and implemented factors to improve the effectiveness of communication during transitions of care []. It has been proposed that efforts to standardize the content and processes of patient handovers (eg, shift reports) ensure consistency in the exchange of vital information and effectively improve communication and, thus, patient safety []. Despite few details about what the precise contents of any handover communication should be, standardizing processes (eg, describing the patient) could be a starting point for choosing the contents (eg, patient name, age, and current condition). To ensure that information transfer in complex care environments is safe and effective, specific information about each process should form a part of any two-way communication []. There is little empirical evidence in the current literature of any link between patient safety and the effective transfer of information during handovers []. We used the Delphi survey method as our framework for a handover content-selection process based on the results of several rounds of questionnaires sent to a selected panel of nurse experts []. This approach, according to Tong et al [] and the World Medical Association [], used the following: structured anonymous communication between experts to gather consensus perspectives about an issue or topics that can then be used to inform decision making or to agree about methods of functioning. An e-Delphi study involves a number of rounds of web-based questionnaires in which experts are requested to provide their opinions on precise topics []. They do so independently, but after the first round, they are aware of the other participants' aggregated opinions when making their second-round decisions. The goal is to reach a consensus. The e-Delphi method's key features are iteration and anonymity, which were found to be particularly advantageous for a multisite hospital dealing with several medical specialties. The anonymous, web-based format encourages participation and honest opinion sharing by large numbers of panel members and prevents senior or influential individuals from monopolizing or influencing discussions. This is important in the hierarchical environment of a health care institution. The higher the number of handovers, the more significant risks patients face, although little is known about the exact mechanisms by which handovers destabilize care. Information management at nursing shift changes has been highlighted as being particularly prone to mistakes [,]. The general themes involved in clinical nursing handover standards are affected by a range of factors that contribute to define how smooth and safe they are for patients [,]. A nursing handover is a vital element in the continuity of care []. Transitions in care are notable periods of vulnerability in a patients' treatment journey []. Transferring responsibility for a patient's care to another health care professional increases the chances of an error occurring, especially if key information is communicated inaccurately and inefficiently []. Any inaccurate, unclear, or incomplete transfer of information increases the risks of potentially severe errors [,]. This study aimed to use a modified e-Delphi survey to design an evidence-based, nursing handover standard for inpatients for use at shift changes or internal transfers between the hospital wards of a multisite public hospital in Switzerland. **Methods** **Design** **Overview** **Study design** was based on a previously published protocol [] describing the use of a multiround survey of a targeted panel sample of 264,300 nurse experts to build a consensus for the contents of an evidence-based nursing handover standard. A rounds-step Delphi technique documented by Keeney and al [], Burchell and al [], Slade and al [], and Cole et al [] was used for this study. Formal reporting on the qualitative data from responses to open questions and on the focus group was based on a checklist of the most common methods of data collection in qualitative health care research []. **Comprehensive Scoping Review** to Design the Components of a Web-Based Modified e-Delphi Survey **A comprehensive scoping review** of the literature was made to find the components of effective, evidence-based, clinical nursing handovers. Predefined terms were used to search for published articles in the following electronic databases, from inception until September 30, 2018: MEDLINE (Medical Literature Analysis and Retrieval System Online) via PubMed (from 1946), Embase (from 1947), CINAHL (Cumulative Index to Nursing and Allied Health Literature) (from 1937), Web of Science (from 1900), ScienceDirect, and Wiley. The bibliographies of all relevant articles were hand-searched, and Google Scholar was used to search for unpublished studies. **Data Collection Process** **Data collection** was preceded by a comprehensive, systematic scoping review of the components of an evidence-based clinical nursing handover standard. This enabled us to draw up a list of potential handover items to be decided on using a web-based, modified e-Delphi survey. **Data collection** began in mid-September 2018 and ended in mid-December 2018. **Setting and Population** **The study** was conducted at a multisite public hospital that recorded over 40,000 individual hospitalizations in 2018; it is composed of two hospital centers in two linguistically and culturally different regions of a single Swiss canton []. Each hospital center has standard medical hospitalization wards to fulfill its mission of providing general public health care; however, the more complex medical specialties are only present at the French-speaking hospital center. The French-speaking hospital center has 39 acute care and eight psychiatric wards, with 1134 full-time-equivalent health care professionals. The German-speaking hospital center has 15 acute care and three psychiatric wards, with 390 full-time-equivalent health care professionals. Each acute care ward has a triad of nurse experts: a registered nurse clinical-educator, a student-success coach, and a nurse supervisor. Each hospital center's nursing managers and departmental supervisors supported and encouraged eligible staff to participate actively in the data collection process. We aimed for a targeted anonymized panel of nurse experts from both the French-speaking and German-speaking hospital centers. **Knowledge Synthesis for the Selection of Items for the Nursing Handover Standard** **Investigators** examined the review's findings at two item-selection meetings and chose the potentially relevant components of an evidence-based nursing handover standard to be included in the e-Delphi panel survey. **Present** the main potential components. The questionnaire was made available in French and German; it was trialed with four clinical experts not involved in the study, who were asked to assess items for clarity, wording, and understandability. **Culture and attitude for good handover practices**: **Respectful and collaborative attitude** **Proactive listening** **Positive, factual language** adapted to patients, situations, and professionals **Confidentiality** **The handover** **Use positive, factual language** adapted to patients, situations, and professionals; **4. Respect confidentiality**; and **5. Conduct the handover in a calm and quiet environment to prevent interruptions**. **The preparatory phase for handover** includes the coordination of activities to gather the different sources of information to be communicated; **6. Make a clinical assessment before the handover**; **7. Regroup different sources of information**; **8. Update patient records**; and **9. Reconsider and reanalyze information**. **The handover phase itself** should include the communication of all patient-specific information; **10. Use a mnemonic technique to guide communication and format content chronologically**; **11. Face-to-face handovers give nurses the opportunity to ask questions**; **12. Information technology (IT) should support data access to patient's complete history and health status**; **13. Patient records should allow the traceability of decisions and follow-up**; **14. IT should support data updates**; **15. Flexible IT support should allow for adaptability for each specialized unit**; **16. Handovers at the patient's bedside risk breaching confidentiality**; and **17. Handovers at the patient's bedside enable a better understanding of their values and preferences**. **A minimum dataset should be transmitted**: **18. Provide a summary of patient's hospitalization history and care planning**; **19. Provide an assessment of the disease, including severity**; **20. Present a prognosis of health status**; **21. Provide a list of allergies**; **22. Present a reanimation status**; **23. Provide a list of medication**; **24. Present laboratory results**; **25. Update vital signs**; and **26. Provide a list of all patient activities**. **View this figure** **Figure 4**. **Distribution of round 1 opinions on nursing handover items given by the panel of nurse experts from the German-speaking region's hospital center (n=85)**. **The numbers of participants who rated each item according to the legend options are indicated within the respective colored portions of each bar**. **The 26 items, within their respective categories, are listed here**. **Good handover practices** are carried out in a collaborative spirit: **1. Adopt a respectful and collaborative attitude**; **2. Adopt proactive listening**; **3. Use positive, factual language** adapted to patients, situations, and professionals; **4. Respect confidentiality**; and **5. Conduct the handover in a calm and quiet environment to prevent interruptions**. **The preparatory phase for handover** includes the coordination of activities to gather the different sources of information to be communicated; **6. Make a clinical assessment before the handover**; **7. Regroup different sources of information**; **8. Update patient records**; and **9. Reconsider and reanalyze information**. **The handover phase itself** should include the communication of all patient-specific information; **10. Use a mnemonic technique to guide communication and format content chronologically**; **11. Face-to-face handovers give nurses the opportunity to ask questions**; **12. Information technology (IT) should support data access to patient's complete history and health status**; **13. Patient records should allow the traceability of decisions and follow-up**; **14. IT should support data updates**; **15. Flexible IT support should allow for adaptability for each specialized unit**; **16. Handovers at the patient's bedside risk breaching confidentiality**; and **17. Handovers at the patient's bedside enable a better understanding of their values and preferences**. **A minimum dataset should be transmitted**: **18. Provide a summary of patient's hospitalization history and care planning**; **19. Provide an assessment of the disease, including severity**; **20. Present a prognosis of health status**; **21. Provide a list of allergies**; **22. Present a reanimation status**; **23. Provide a list of medication**; **24. Present laboratory results**; **25. Update vital signs**; and **26. Provide a list of all patient activities**. **View this figure** **Table 2**. **Analysis of the survey statement scores from the French-speaking and German-speaking hospital centers**. **Statements and their categories** **French-speaking hospital center (n=157)** **Mean (SD)** **Median (IQR-75)** **Consensus, %** **Mean (SD)** **Median (IQR-75)** **Consensus, %** **Good handovers** are carried out in a spirit of cooperation; **1. Adopt a respectful and cooperative attitude** **4.9 (0.45) (5)97.54** **8 (0.35) (5)100.2** **Adopt proactive listening** **4.8 (0.65) (5)96.24** **9 (0.35) (5)100.3** **Use positive, factual language** adapted to patients, situations, and professionals **4.8 (0.65) (5)96.84** **7 (0.45) (5)98.64** **Respect confidentiality** **4.9 (0.65) (5)96.84** **8 (0.45) (5)100.5** **Conduct the handover in a calm, quiet environment to prevent interruptions** **4.5 (1.05) (4)87.94** **5 (0.55) (5)98.67** **The preparatory phase for handover** includes the coordination of activities to gather the different sources of information to be communicated; **6. Make a clinical assessment before the handover**; **7. Regroup different sources of information**; **8. Update patient records**; and **9. Reconsider and reanalyze information**; **4.4 (1.15) (4)77.14** **0 (1.14) (4)67.18** **11. Face-to-face handovers**, which give nurses the opportunity to ask questions; **4.8 (0.85) (5)95.54** **8 (0.85) (5)94.31** **12. Information technology (IT) should support data access to patient's complete history and health status**; **4.7 (1.05) (5)93.04** **4 (1.15) (4)82.91** **Patient records** should enable the traceability of decisions and follow-up; **4.9 (0.65) (5)96.24** **6 (0.95) (5)88.61** **14. Information technology** should support data updates; **4.9 (0.85) (5)95.55** **0 (1.25) (5)85.71** **15. Flexible information technology** support should allow for adaptability by each specialized unit; **4.1 (1.55) (4)69.04** **4.9 (1.05) (5)90.01** **Handovers at the patient's bedside risk breaching confidentiality**; **3.8 (1.34) (4)68.84** **0 (1.54) (4)71.41** **17. Handovers at the patient's bedside enable a better understanding of their values and preferences**; **3.5 (1.44) (4)58.64** **7 (1.14) (5)88.64** **A minimum dataset should be transmitted**; **18. Provide a summary of the patient's hospitalization history and care plans** **4.5 (0.95) (4)93.04** **6 (1.05) (5)88.61** **19. Provide an assessment of the disease, including severity**; **4.6 (0.95) (5)93.64** **4 (1.15) (4)85.72** **20. Present a prognosis of health status** **4.1 (1.34) (4)76.44** **3 (1.45) (4)77.12** **21. Provide a list of allergies** **4.6 (1.25) (5)87.94** **5 (1.45) (5)81.42** **22. Present the patient's reanimation status** **4.8 (1.35) (5)82.84** **6 (1.35) (5)84.32** **23. Provide a list of medication** **4.1 (1.65) (4)69.04** **2 (1.55) (4)77.12** **24. Present laboratory results** **3.8 (1.54) (4)65.64** **0 (1.84) (4)65.78** **25. Provide an update on vital signs** **4.2 (1.54) (4)73.24** **2 (1.44) (4)80.02** **26. Provide a list of all patient activities** **4.3 (1.44) (4)79.04** **1 (1.14) (4)81.44** **The survey** used a 5-point Likert scale, ranging from Strongly agree (scoring 5) to Strongly disagree (scoring 1), to describe participants' opinions on whether items should be included in the evidence-based clinical nursing handover standard. **n**Nonconsensus:

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