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RESEARCH

SHIFT HANDOVER, EFFECTIVE COMMUNICATION, AND THE SBAR METHOD, IN THE PERCEPTION OF NURSES IN A CORONARY CARE UNIT

PASSAGEM DE PLANTÃO, COMUNICAÇÃO EFETIVA E O MÉTODO SBAR, NA PERCEPÇÃO DOS ENFERMEIROS DE UMA UNIDADE CORONARIANA

EL CAMBIO DE TURNO, LA COMUNICACIÓN EFECTIVA Y EL MÉTODO SBAR EN LA PERCEPCIÓN DE LOS ENFERMEROS DE UNA UNIDAD DE CUIDADOS CORONARIOS

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ABSTRACT

Objective: to identify the perceptions of nurses in a coronary care unit about the relationship between shift change, effective communication, and the SBAR method. **Method:** descriptive exploratory study with a qualitative approach that sought to identify nurses' perceptions about the relationship between shift change, effective communication, and the SBAR method in the intensive care unit in the process carried out between work shifts, with indications for the construction of a structured instrument to guide and lead the shift change, with the participation of 12 nurses from a coronary intensive care unit. Data were obtained from January to July 2020 through a face-to-face workshop before the pandemic, and questionnaires were subjected to thematic analysis. **Results:** three categories were listed: Organization of the shift change with nurses and Nursing technicians; Instrumentalization of the shift change between the Nursing teams; and SBAR Method in the shift change, as a basis for the elaboration of the shift change instrument. It was evidenced that effective communication is an influencing factor in the shift change to carry out Nursing care in a continuous way, avoiding adverse events to patients. **Conclusion:** it is confirmed that strategies involving hospital management, such as equipping and training the team that is in the front line of the duty activity, add and enrich the systematized and humanized care.

Keywords: Health Communication; Patient Safety; Nursing; Shift Work Schedule; Intensive Care Units.

RESUMO

Objetivo: *identificar as percepções dos enfermeiros de uma unidade coronariana sobre a relação entre a passagem de plantão, comunicação efetiva e o método SBAR.* ***Método:*** *estudo descritivo exploratório com abordagem qualitativa que buscou identificar as percepções dos enfermeiros sobre a relação entre a passagem de plantão, a comunicação efetiva e o método SBAR na unidade de terapia intensiva no processo realizado entre os turnos de trabalho, com indicativos para a construção de um instrumento estruturado para orientar e conduzir a troca de turnos, com a participação de 12 enfermeiros de uma unidade intensiva coronariana. Os dados foram obtidos no período de janeiro a julho de 2020 por meio oficina presencial antes da pandemia, e questionários foram submetidos à análise temática.* ***Resultados:*** *foram elencadas três categorias: Organização da passagem de plantão com enfermeiro e técnico de Enfermagem; Instrumentalização da passagem de plantão entre as equipes de Enfermagem; e Método SBAR na passagem de plantão, como base para a elaboração do instrumento de passagem de plantão. Evidenciou-se que a comunicação efetiva é um fator influenciador na passagem de plantão para a realização do cuidado de Enfermagem de forma continuada, evitando eventos adversos aos pacientes.* ***Conclusão:*** *confirma-se que, estratégias envolvendo a gestão hospitalar, como instrumentalizar e capacitar a equipe que está na linha de frente da atividade do plantão, acrescentam e enriquecem o cuidado sistematizado e humanizado.*

Palavras-chave: *Comunicação em Saúde; Segurança do Paciente; Enfermagem; Jornada de Trabalho em Turnos; Unidades de Terapia Intensiva.*

RESUMEN

Objetivo: *identificar las percepciones del personal de enfermería de una unidad de cuidados coronarios sobre la relación entre el rostering, la comunicación efectiva y el método SBAR.* ***Método:*** *estudio exploratorio descripti-vo con abordaje cualitativo, que buscaba identificar las percepciones de los enfermeros sobre la relación entre el paso de planta, la comunicación efectiva y el método SBAR, en la unidad de terapia intensiva en el proceso realizado entre los turnos de trabajo, con indicaciones para construir un instrumento estructurado para orientar y conducir la búsqueda de turnos con la participación de 12 enfermeros de una unidad intensiva coronaria. Los datos se obtuvieron de enero a julio de 2020, mediante un taller presencial antes de la pandemia y cuestionarios sometidos a análisis temáticos.* ***Resultados:*** *se enumeraron tres categorías: Organización del paso de planta con el enfermero y el técnico de enfermería, instrumentalización del cambio de turno entre los equipos de enferme-ría y método SBAR en el cambio de turno, como base para la elaboración del instrumento de cambio de turno. Se demostró que la comunicación eficaz es un factor que influye en el paso de la planta para la realización del cuidado de la salud de forma continuada, evitando eventos adversos a los pacientes.* ***Conclusión:*** *se confirma que las estrategias que implican a la dirección del hospital, como: potenciar y formar a este equipo*

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que está en primera línea, en el liderazgo de la actividad de guardia, suma y enriquece la atención sistematizada y humanizada.

Palabras clave: *Comunicación en Salud; Seguridad del Paciente; Enfermería; Horario de Trabajo por Turnos; Unidades de Cuidados Intensivos.*

INTRODUCTION

The World Health Organization (WHO) has been promoting programs in health services with the potential to improve patient safety, bundling several complementary interventions to sustain improvements over time. These programs aim to standardize the critical content of communication during a transfer to provide continuity of care and may encourage the use of some tools and methods.[1]

Among the goals internationally recommended by the Joint Commission International on adverse events, communication is the second solution, applied specifically in three situations: in the patient transfers between units and/or services; in shift handover between work shifts; and in communication with the patient and his family during hospitalization.[2]

When a patient enters the hospital unit, he moves through several intra-hospital environments and interacts with different professionals. If there is no effective communication between professionals in these sectors, information is lost, which may harm and/or delay treatment or even favor the occurrence of an adverse event that can result in death.[3,4]

At the same time, information is continuously generated on different care procedures and multidisciplinary assessments, which requires effective communication. This has repercussions on the need to adopt measures to reduce adverse events caused by communication failures. The shift handover between the health teams is an example of this information generated, considered tools for the prevention of failures and planning errors during care.[3]

The problem related to the impairment of an effective communication process between professionals has been pointed out in the communication that occurs during shift handover. This shift handover is one of the activities carried out by the Nursing team at the end of the work shift, in which they give information about the continuity of the care process.[5] Some of the problems in this practice are the omission of data, lack of precision or consistency of information, interruptions, and frequent noises that make it impossible to clarify the message to be transmitted.[6] On the other hand, one of the gaps in this process is the embarrassment of professionals in expressing in front of co-workers, making difficult the communication process between teams, being essential to the organization and maintenance by the nurse.[7]

The predominance of failures in institutional communication processes is identified as a source of risk of adverse events.[8,9] In this sense, the standardization of information about the patient is one of the strategies such as the Situation, Background, Assessment, and Recommendation, known as SBAR. The SBAR provides a structure for professionals to communicate about the patient's situation and condition, allowing professionals to anticipate the next steps and, if necessary, change their mental model, helping to plan strategies aimed at adopting safe practices.

In a coronary intensive care unit (CICU) of a health institution, there is a need to implement an instrument and an adequate flow for recording the information that will be transmitted during the shift handover, ensuring the continuity of care and, consequently, patient safety.

Therefore, we defined a research question: what is the perception of nurses in a coronary care unit about the relationship between the shift handover, effective communication, and the SBAR method? With this, we seek to meet the objective of identifying the perceptions of nurses in a coronary care unit about the relationship between the shift handover, effective communication, and the SBAR method.

METHOD

This is a descriptive, exploratory, qualitative research, carried out in a CICU of a health institution with 15 beds, five of which are for patients in the postoperative period and 10 for clinical cardiovascular patients.[10]

At the CICU, there are 18 nurses. The research participants met the inclusion criteria - being a nurse and working in this unit during the time of data collection - and the exclusion criteria - being on sick leave or award, vacation; being working in the sector for less than six months. After applying the inclusion and exclusion criteria, we obtained a sample of 12 nurses, considering that two were on sick leave, two were on vacation, one was on premium leave and one did not want to participate in this construction. We guaranteed the anonymity of the participants using the letter N followed by a sequential number.

The data collection period was from January to July 2020. We contacted the nurses to explain the study, make the individual invitation to participate in the research, and collect the signature on the informed consent form.

The data collection technique involved a lecture held in person, to raise awareness about Communication, Shift handover, and the SBAR technique. It started with sensitization of the participants through an experience organized by two psychologists of the institution. After that moment, the existing forms of communication in different countries and an adult intensive care environment were explained, including the emergence of SBAR and the modes that have been used in each country by one of the researchers. Then, a questionnaire was applied that contained the following questions: how do you carry out your shift handover? What do you understand about effective communication? What do you think about having a structured instrument to carry out the shift handover? Justify it. In your opinion, what information is needed to carry out the shift handover in the SBAR method? Cite it. This questionnaire was returned to one of the researchers shortly after completion. At the end of the activity, we thank the participants.

The data that emerged from the questionnaires were organized and analyzed according to the Thematic Analysis proposed by Minayo.[11] The pre-analysis phase consisted of transcribing the questionnaire responses in full, with storage in the Microsoft Word text editing program. In the material exploration phase, after careful reading, the participants' reports were highlighted in the text with different colors, and codes were extracted for the elaboration of **three thematic categories**. The treatment of the results with the interpretation of the data generated the discussion according to the current literature.

The research was approved by the Research Ethics Committee of the *Instituto de Cardiologia de Santa Catarina*, under Opinion number 3,804,074.

RESULTS

Due to the thematic analysis of the data, we listed three categories: Organization of the shift handover with nurses and Nursing technicians; Instrumentalization of the shift handover between the Nursing teams; and SBAR Method on shift handover.

Organization of shift handover with nurse and Nursing technician

In this category, we highlight the importance of the Nursing team in this context and the need to improve communication in the shift handover between work shifts, and the adoption of standardized methods for transmitting the information. In this way, the team will have a deeper understanding of the patient's clinical situation and basic human needs, in line with a Nursing theory that supports the actions and, consequently, the systematization of this care. Thus, the shift handover is configured as a dialogic and learning space.

The organization of the shift handover requires that the messages are clear and coherent, favoring the second goal of the World Health Alliance for Patient Safety, that is, effective communication, which directs communication in health institutions and, more specifically, communication during the shift handover.[12]

> *Currently, the shift handover is carried out with the team* (technicians and nurses)*, in which important information is given about the patients: how they spent the period, what they are receiving and what was suspended.* (N12)

> *When the employee on duty* (minimum) *arrives, I start giving information about the bed and patient's name, main diagnosis or postoperative date and type of surgery, and if there was an allergy. I describe the physical examination with an emphasis on changes. I report what was done during the shift, what still needed to be done* (exam procedures)*, and the goals.* (N2)

> *Generally, I don't always do it in a group. I, as a nurse, using my work method* (draft) *or following the sequence of the shift handover of the previous colleague, inform about the patient, his clinical diagnosis, evaluations, and pending issues, in continuity, the technician in charge complements the information.* (N6)

Study participants recognized the need to improve communication during shift handover between work shifts and considered it necessary to adopt standardized methods for transmitting information so that everyone could effectively understand what was informed.

> *Effective communication is when the listener can absorb, understand and process information from the speaker* (person who speaks). (N4)

> *I understand that for effective communication to take place, we must be attentive and organized in the information relevant to patients attending during the period in which they are under our care.* (N12)

The professional who works in the hospital environment needs theoretical deepening by Wanda de Aguiar Horta on the clinical situation of the patient and the theory of basic human needs. The performance of a

physical examination permeates the deepening of how diseases are expressed in signs and symptoms and linked with Nursing diagnoses and interventions. One participant, after completing the questionnaire, noted that it would be necessary to use Wanda de Aguiar Horta's Theory as a background to conduct the shift handover, promoting her organization. Another relevant aspect is that none of the participants mentioned the Nursing diagnosis as an important factor, but they refer to the medical diagnosis.

> *There is a fundamental importance for me,* ***which is systematized care****. In this way, it is impossible to stimulate and lead the professional to* ***seek and deepen into the information inherent to the patient and family,*** *it is to have* ***an instrument where I can*** *write everything down, working as a script that is a reminder for doubts during the shift.* (N4)

> *I give the patient information to the nurse and technician in charge, sometimes it is possible to do it for all the* [Nursing] *technicians in the room* (bedside). ***I prioritize the diagnosis as*** *an Immediate postoperative period and after cephalocaudal formations and activities performed with that patient during the period.* (N7)

The instrumentalization of the shift handover between the Nursing teams

This category reveals the need for an instrument for the shift handover. This instrument is a space for the continuity of Nursing care through the information described with a sequence that promotes clinical reasoning and for the recording of facts that imply Nursing care. These aspects appear in the different reports of the study participants.

> *I do the written shift handover, most of the time I inform the diagnosis, reason for hospitalization; I inform how the patient is at the moment, what was done during the intervention period and what was left as a goal, after a multi-professional visit, if there was any pending if any exam or opinion is awaited.* (N8)

> *I think it would be a good instrument to standardize the information given and reduce forgetfulness.* (N10)

> *I carry out the shift handover with an instrument that summarizes the complications and analysis of some changes, such as dressings, procedures that will be performed, procedures that have been suspended, notifications that have been made, and pending issues that remain to be resolved.* (N1)

SBAR method on shift handover

The SBAR method was presented to the participants during the sensitization and workshop in which they were motivated to reflect. Thus, they indicated the contents that should be included in an instrument for the shift handover.

> *In the letter of S - Current situation: evaluation of the clinical picture, diagnosis, procedure that was performed. B - Brief history: Vital signs, arrhythmias, drugs in use, use of products in dressings, parameters of mechanical ventilation. A - Situation analysis: Evaluate the measures that were carried out and present results, evaluate therapy and procedures that were performed. R - Recommendation: recommend care that should be performed, recommend suggestions for improvement in the clinical condition.* (N1)

> *In the letter S - Medical diagnosis, the reason for hospitalization, comorbidities, and other relevant information. B - How the patient is at the moment, according to the nurse's assessment. A - Interpretation according to the professional's assessment and whether there were interventions in the period. R - Goals to be met due to the multi-professional visit, pending issues of any nature, exams, medications not standardized in the institution, and opinions from other professionals.* (N8)

In the letter **S - Situation**, the main medical diagnosis and the reason for hospitalization are indispensable items that must be mentioned and have been mentioned by nine people. Another three people mentioned the patient's identification, two mentioned the description of the clinical condition, one the allergy, and another the comorbidities.

In the mnemonic, composed of the letter **B - brief history**, the physical examination was mentioned by 10 participants, whose logic follows the theory of basic human needs, indicating those changed in the period. Intercurrences were reported by three people, medical diagnosis by two, major laboratory tests altered by two participants, altered vital signs and drugs in use by one, and history by one.

In letter **A – Assessments**, nine participants indicated the evaluation of the measures that were carried out to resolve the intercurrences, three described evaluating therapy and two participants indicated that it is important to report the procedure performed during the work

shift. They also mentioned the record of dressings, devices, pending duty, and dependence on self-care.

In the letter **R - Recommendation**, seven of the participants mentioned the goals discussed in the multidisciplinary visit, whose discussion takes place daily at 11 am with the presence of a multi-professional team, composed of nurses, Nursing technicians, physicians, physiotherapists, psychologists, nutritionists, and social worker. During this meeting, they discuss actions to improve the patient. Seven participants suggested including pending exams, as well as pending procedures (three participants), pending opinions (two participants), fasting (two participants), and suggestions for improving the clinical condition (five participants). One participant did not comment.

DISCUSSION

The results show that nurses consider it necessary that the shift handover is carried out between the Nursing teams and with a record of the information given at each shift. This practice aims to transmit, in an objective, clear and concise way, information about the occurrences during a given work shift, allowing professionals to have an overview of the sector and the evolution of patients, facilitating the planning and organization of their activities.[13]

The shift handover at the bedside was suggested as a way to improve the quality of the information given, because, in this format, the professional can observe the patient and, in a continuous way, transmit the recorded information and those that may have been sublimated during the work time. This activity needs preparation before being performed, such as organizing time and records. The shift handover favors a moment of continuing education, with space conducive to dialogue, clarification of doubts, and reflection by the Nursing team, aspects that contribute to care based on scientific evidence. It is up to the nurse to coordinate this activity, taking advantage of the moment to match the information from the shift, aiming at guidance and improvement, reorganizing the Nursing care plan, and listing the priorities and actions that involve patients.[13]

With the systematization of the shift handover, the time of Nursing care is organized and communication is perfected, with the engagement of the teams between shifts.[14]

The communication process dynamically permeates the entire activity of the hospital area, as the flow of information and the number of professionals from the different care teams - also the great demand for activities - entail a need for constant updating and exchange of information between the teams. The predominance of failures in institutional communication processes is a source of risk for the occurrence of adverse events.[3]

The second international patient safety goal describes how communication is fundamental for the continuity of Nursing care, as it is continuous, occurring at different times of the day. The shift change is recognized as a moment of communication between work shifts. For this reason, failures in this communication process compromise patient safety, becoming the biggest cause of adverse events.[15]

An unrecorded or incomplete shift handover can interfere with patient safety, which can be caused by the loss of important information for the quality of care and its continuity in a safe way.[16] These communication failures can be linked to interferences such as parallel conversations, the noise of hospital medical equipment, and delays from colleagues.[17] In the health area, we estimate that ineffective communication is among the main causes of more than 70% of care errors, that is, adverse events,[18] which is of great concern to the institutions.

We observed in the reports that communication failures resulting from the shift handover interfere with the continuity of Nursing care, but they are difficult to measure, as they are not recognized as adverse events. In this sense, they are not recorded, hindering to relate the communication failure to the occurrence of the adverse event and the quantification.[15] In the studied institution, there is no record of the adverse event caused by a communication failure, which is why there is no data for this indicator. The other indicators are collected, calculated, and published by the Patient Safety Center of this institution. Most of this collection is based on records of adverse events and the active search of members of this sector.

The indicators are recognized as a management tool for good clinical practices in the hospital environment. In a study carried out to analyze how nurses recognize and use indicators in care practice, it was concluded that this measurement tool helps in the process of continuous improvement of care and decision-making about care actions, as in good care practices.[18,19]

We also observed that the transmission of verbal information face-to-face among the multidisciplinary team, with the aid of standardized registration, is considered one of the most effective forms of communication. However, it is important to consider that the conditions of the place, respect for timetables, duration, and the

participation of the team must follow structured forms, preferably computerized.[3]

In the scenario of this research, the shift handover is carried out at the three Nursing stations at 7:00 a.m., 1:00 pm, and 7:00 pm. The participants are nurses and Nursing technicians, and the shift handover is directed by the nurse and complemented by the Nursing technician. Professionals can define the relevant information given during shift changes, but the existence of several records in the institution's computer system hinders capturing this data. This is a limitation as there is no possibility to change records as per demand.

In this sense, the construction of a shift handover instrument in the view of nurses, reaffirmed by the author, is a viable solution. The SBAR technique logically allows the organization of information to avoid failures that interfere with quality and safety, facilitating the exchange of information by structuring communication between Nursing teams in care.

Nursing care is carried out through the Nursing Process, whose theory is Wanda de Aguiar Horta, and the steps are sequential and include the Nursing diagnosis, which was not mentioned by the participants. The development of clinical reasoning for the construction of the Nursing diagnosis based on anamnesis and clinical examination directly favors the autonomy of the profession and confers social recognition of the profession. Although nurses perform anamnesis and physical examination, they are not in the habit of recording. In this sense, the participants have a non-systematized, although the complementary, sequence of work, pointing to the constitution of the letter B - brief history and giving continuity to the other work shift.

All items chosen by the participants reflect the assessment of the patient's clinical status in the period so that the next team can continuously analyze the patient's general condition to prepare his care plan, prioritize the most severe patient, and manage to minimize the failures of ineffective communication.

Nurses need to empower with knowledge about the care of critically ill patients. For this reason, training nurses to lead this activity on duty adds to and enriches care, since, to carry out this activity, it is necessary to know the patient, perform the physical examination, collect the history, list the Nursing diagnosis, and the care. Therefore, this study can add knowledge to nurses, but new communication workshops need to be carried out since they reflect putting oneself in the other's shoes.

The limitation of the study was the lack of research in the area of communication, in Brazil, which would help in the discussion and enrich the debate.

CONCLUSION

The relationship perceived by nurses between the shift handover, effective communication, and the SBAR method is complementary to the execution of this activity in a safe way among the Nursing teams, avoiding adverse events. A weakness we found is that there are few studies on the use of the SBAR method in an adult intensive care unit to change handover between work shifts, especially in the Brazilian reality. New studies need to be carried out to strengthen this debate.

The study shows that the adoption of a structured and systematized method will facilitate the organization of information and guide nurses in the shift handover between work shifts, and some hospital management tools can be used.

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