Enhancing person-centred care in inpatient mental health settings through supported person-side handover: a multi method study.

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Abstract

Background

Many nursing contexts have introduced bedside handover, where the person in care participates in the transfer of clinical information, with benefits for person, carers, and clinicians. This type of handover has been implemented across a number of mental health settings, but there is limited evidence regarding implementation approaches or of practice change. This study reports the development and evaluation of a co-produced education and support package.

Aim

To evaluate changes in nurses' practice regarding bedside (person-side) handover following implementation of a structured education and support package.

Design

Multi-method design incorporating nurse surveys and chart audit.

Methods

The survey and audit were conducted in 2019-20 on two inpatient mental health units in a metropolitan health service immediately prior to, and 6 months after, implementation, with 70 survey responses and 52 files audited. Non-parametric tests assessed change, and text comments were reported.

Results

Significant improvements were observed in nurses' reports of confidence, the ability to maintain privacy, identified benefits for the person and in information transfer. In contrast, the chart audit identified no change in documentation of this practice.

Conclusions

The implementation of a co-produced education and support package demonstrated positive practice change in engaging people receiving care in handover. This approach to handover provides increased opportunity for nurses to work in partnership with people receiving mental healthcare, facilitating collaborative person-centred care and shared decision making.

Impact Statement

Person-side handover provides nurses with opportunities to work more collaboratively with consumers, reduce misinformation or errors, and enhance person-centred recovery-oriented practice. Co-production and support facilitated improvements in the accuracy and relevance of handover content and appear to be key elements worthy of further investigation.

Keywords

Clinical handover, hand off (patient safety), consumer participation, mental health, person-centred care, nurses, patient bedside

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Introduction

The involvement of consumers in clinical handover remains an area of debate in mental health and drug and alcohol care settings. Despite the widely acknowledged benefits to partnerships in care (Cowan et al., 2018; Mullen et al., 2020; Slade et al., 2019) concerns persist amongst mental health professionals regarding the participation of consumers in clinical handover. Issues raised include perceived challenges to privacy and confidentiality, staff discomfort in discussing sensitive issues in the presence of the person, and consumers' and carers' level of comfort with participation (Cowan et al., 2018; Isobel, 2019). Implementation of this practice in mental health settings is consequently rare, and more rarely studied (Olasoji et al., 2019). In mental health contexts, the term bedside handover may be a misnomer, as it is not often conducted at the bedside. Further, while the term consumer is often adopted in the literature (Costa et al., 2019; Flores-Sandoval et al., 2021), a more context- and process-specific term is *person-side handover*, used throughout this manuscript. This paper reports an initiative to enhance collaborative person-centred mental health care through person-side handover using a co-produced education and support package.

Background

Clinical handover involves the transfer of information, professional responsibility, and accountability for a person or persons receiving care, from one provider or a team of providers to another. Effective handover enhances communication and has been linked to

reduced adverse events and improved safety (Hada et al., 2018). The development of structures and tools to support the implementation of this process has received considerable attention in health services and the research literature (Bukoh & Siah, 2020). A relatively recent innovation in clinical handover has been bedside handover (Tobiano et al., 2018), where the person, at the bedside, is involved in the communication of clinical information during the change of shift (Scheidenhelm & Reitz, 2017).

Bedside handover has been adopted in many medical and surgical inpatient settings (Manias & Watson, 2014). The benefits of engaging consumers and carers in handover include increased consumer satisfaction, greater empowerment, and improved health literacy (Bradley & Mott, 2014). The practice aligns strongly with person-centred care and shared clinical decision-making, and has been incorporated into standards and policies that mandate such partnering (e.g. NSW Health, 2019). In mental health settings person-side handover has the potential to extend the benefits identified in other settings, aligns with the intent of Australia's national recovery focus for mental health (Cowan et al., 2018), and provides a platform for recovery-oriented practice (MacLeay et al., 2020). However, despite this alignment, the research evidence, and the policy mandate, there are few studies that report investigations of this practice in mental health settings (Cowan et al., 2018; Olasoji et al., 2019; Olasoji et al., 2018).

Potential benefits notwithstanding, a number of challenges have been identified to the implementation of bedside or person-side handover. Possession of the knowledge, skill, and confidence to carry out person-side handover is a significant barrier (Slade et al., 2019) and a vital area for exploration. In mental health, nurses have expressed their concerns about their ability to carry out a concise and collaborative handover using appropriate recovery focused language to ensure consumers' needs are addressed (Cowan et al., 2018; Olasoji et

al., 2018). Nurses in both general and mental health settings have expressed low confidence in their ability to conduct handover while maintaining confidentiality. Mental health nurses have expressed a high degree of comfort associated with the traditional practice of conducting handover in closed nurses' offices or 'staff space' (Isobel, 2019). The specific concern is that sensitive information may be overheard by other consumers or family members, violating privacy, and potentially impacting care (Cowan et al., 2018; Mullen et al., 2020; Tobiano et al., 2018). This accords with mental health consumers' views (Olasoji et al., 2018), but contrasts with evidence from general nursing contexts, where nurses see privacy as more of a concern than consumers (Oxelmark et al., 2018). Time constraints are also a factor (Isobel, 2019; Scheidenhelm & Reitz, 2017), as are negative attitudes towards the practice (Olasoji et al., 2019; Oxelmark et al., 2018), and context specific issues such as the unit's culture and physical environment.

However, positive change in attitudes and practice have been identified consequent to context-aware, supportive programs (Olasoji et al., 2019), suggesting that implementation is best developed and applied incorporating the local context with ongoing support. In the present study, a co-produced education and support package was developed to provide nurses with the skills, confidence, and support to undertake person-side handover in a mental health setting.

Education and support package

Successful implementation of person-side handover needs to build understanding, skill, and confidence. This may be achieved through a combination of context-specific education, local leadership, and ongoing support (Scheidenhelm & Reitz, 2017). An effective education and support package should embody the philosophy of person-side handover and therefore be

co-produced and co-delivered, which will develop not only the skills required but also emphasise the value and importance of consumer participation in the decision-making process (Anthony et al., 2018). The package introduced in this study was therefore developed collaboratively, centred on a working party that comprised consumer peer support workers and clinical nurses from the participating units. To ensure relevance to the local context, consumers, consumer peer workers, managers, and nurses outside the group were consulted.

This consultation identified focal points for consumers and consumer peer workers of handover content, handover participants, and handover location. For content, consumers noted the importance of concrete information including proposed treatment changes, length of admission, participation in group activities, and the type of *pro re nata* (PRN) medication available to them. Timely information on their mental state and sleep patterns, and personalised approaches to daily goal setting and stress management, were also important. Consumers strongly advocated for active collaboration between nurses and consumers, focused on partnership with positive, recovery-focused, language. They emphasised that handover was one component of an overall approach to active engagement by and with nurses and other staff. A quiet and private space was considered essential.

Nurses also identified the handover should incorporate concrete items such as planned leave or visits, activities of daily living, 'unmet requests', and medication side effects. They emphasised that nurses should be aware of person-specific triggers and of what approaches are most effective to manage stress for that consumer. They too identified the need for collaboration and a private and quiet location. Nurses believed that only the morning to

afternoon shift change would be appropriate for person-side handover, to avoid the need to wake the person early in the morning, and to manage different shift starting times.

This information informed the education and support package, which included face-to-face interaction supported by videos and ongoing mentoring. A key aspect was developing nurses' understanding of why person side handover is important, and how and when it can be practiced effectively. Two videos were developed. One provided a positive demonstration of how to conduct person-side handover, and the other a demonstration of how to *not* undertake the practice. These videos were used to stimulate discussion, reflection, and understanding. Opportunity was provided for questioning and consideration of all views. Senior clinical nurses facilitated delivery of the package over a three-week period to ensure all nurses had the opportunity to participate and understand the process. Subsequently, senior nurses and consumer peer workers provided support and mentoring to staff over a six-month implementation phase. Posters that outlined the process for consumers and carers were placed in prominent places on the units.

Context

Aim

This aim of this study was to evaluate changes in nurses' knowledge, confidence, utilisation, and documentation of person-side handover in two mental health units, following the implementation of a co-produced education and support package.

Design

This multi-method study evaluated changes following the introduction of person-side handover in two mental health units (Figure 1). Multi-method research offers the advantage of data collection using two approaches, alleviating the issue of mono-method bias

(Donaldson & Grant-Vallone, 2002), but does not provide the integrated understanding of mixed-methods research (Halcomb & Hickman, 2015). In the present study, an online survey of clinical nurses assessed their knowledge, confidence, and other perceptions of person-side handover, and an audit of medical records identified documented participation in the practice.

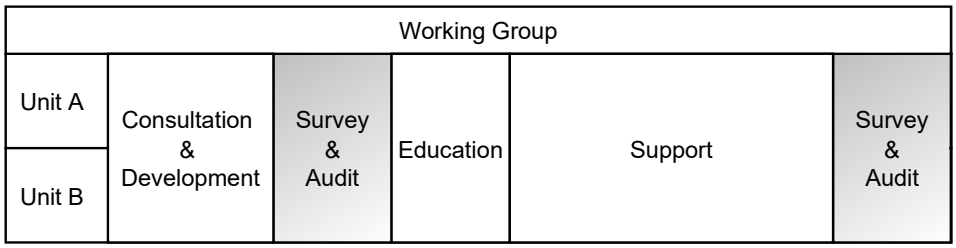

Figure 1 Design

Setting & participants

The study was undertaken on two inpatient mental health units in a metropolitan health service in New South Wales, Australia, between January 2019 and January 2020. Unit A was a 12-bed secure acute tertiary referral and admission unit that provides specialist intensive care for people with significant clinical complexity and risk. A consumer peer worker was on staff and nurses were all registered or enrolled. Unit B was a 20-bed secure long stay rehabilitation unit that facilitated consumer involvement in a wide range of social and diversional programs and activities. Staffing included a consumer peer worker, registered, and enrolled nurses, and nurse assistants. These units were chosen for the study because of the stability of their staffing and the opportunity they provided to introduce and assess the practice in diverse settings. Prior to implementation of the education and support package,

handover practice on the participating units was the more traditional approach whereby nurses met as a group, separated from consumers and carers.

Data collection

Both the survey and audit were conducted immediately prior to implementation (April 2019) and repeated six months later (November 2019).

Survey

The online survey was created in SurveyMonkey© and distributed via email link to all clinical nurses working on the units (n=46). The survey comprised 15 items and space for respondents' comments. Eight items were binary response (yes/no) that assessed nurses' knowledge, confidence, and other perceptions of person-side handover. For example, 'are you familiar with the practice of person side handover', 'do you feel involving the consumer in the handover process is beneficial to the consumer?', 'do you feel confident in your ability to carry out a clinical handover with consumer participation?' and 'do you feel that you can carry out handover involving the consumer while still ensuring consumer privacy and confidentiality?'. The remaining seven items assessed the conduct of handover over the preceding week through agreement with statements scored on a 4-point scale (strongly disagree to strongly agree). Statements included 'the handovers you received have contained all required information to enable you to address the needs of clients in your care', 'the consumer was present or offered to be present during the handover process', 'the handovers you received have accurately described the consumer's needs', and 'the carer or family members views or concerns were discussed in the handover process'. In view of potential nurse participants' previously expressed sensitivities regarding perceived

identifiability, the unit name, nurse demographics, and other potentially identifiable characteristics were not collected.

Medical record audit

The retrospective medical record audit (n=52) captured consumer demographics, the duration of admission to the unit, diagnostic category, and 4 items that assessed consumer and carer engagement. The latter was identified if either the header or body of the record specified 'consumer' or 'carer'. For example, 'reference to consumer involvement in the heading', or 'documentation of carer involvement in the handover body'.

Ethical considerations

Ethics approval was obtained from the health service's Human Research Ethics Committee (2019/ETH11481), and consent to the survey was implied by completion. The STROBE checklist was applied to the development of this manuscript.

Data analysis

Audit data were entered directly into Microsoft Excel© and survey data downloaded in the same format. These data were then transferred to IBM SPSS© version 23 for analysis. Binary data were analysed using valid number and percentage of responses and means calculated for the 4-point scale. Missing data were excluded listwise. Descriptive analyses with non-parametric tests (Chi-square, Mann-Whitney) were used to assess statistically significant differences, designated by p-values ≤0.05. Comments were insufficient in number to formally analyse and are presented verbatim where relevant.

The survey and the medical record audit tool were developed specifically for this study with items derived from the literature or nominated by the working group during the

development of the education and support package. Both tools were reviewed by a panel of clinical experts for face validity with minor amendments made to terminology prior to use.

Results

A total of 70 responses were received to the survey, 29 (63%) before implementation and 41 (89%) after; an overall response rate of 76%. Almost all responses were complete with only seven items missing across the entire dataset. Text comments were provided by 4 respondents before implementation and by 8 after. Fifty-two medical records were accessed for the project, 24 before implementation and 28 after, with diagnostic category not recorded in one file, but no other missing data.

Medical record data provided a description of the consumers on each unit. There was a considerable difference between consumers present on the units (Table 1) with those on the long stay rehabilitation unit being around 20 years older on average, and having considerably longer stays. Most consumers on both units were diagnosed with schizophrenia but there was a greater diversity of diagnoses on unit A. Gender was primarily male although more mixed on unit B. All differences were statistically significant.

Table 1 Participant characteristics, by unit

	Unit A (n=20) N (%)	Unit B (n=32) N (%)	X^2 (df)	p	Overall N (%)
Gender					
Male	20 (100.0%)	22 (68.8%)	7.738 (1)	0.005	42 (80.8%)
Female	0 (0.0%)	10 (31.3%)			10 (19.2%)
LOS					
<2 days	1 (5.0%)	0 (0.0%)	40.557 (5)	≤0.001	1 (1.9%)
2-7 days	5 (25.0%)	0 (0.0%)			5 (9.6%)
1-4 weeks	8 (40.0%)	0 (0.0%)			8 (15.4%)
1-3 months	5 (25.0%)	3 (9.4%)			8 (15.4%)
3-6 months	1 (5.0%)	5 (15.6%)			6 (11.5%)
>6 months	0 (0.0%)	24 (75.0%)			24 (46.2%)
Diagnostic Category					
Schizophrenia	11 (57.9%)	28 (87.5%)	17.215 (5)	0.004	39 (76.5%)
Bipolar Affective Disorder	4 (21.1%)	0 (0.0%)			4 (7.8%)
Drug Induced Psychosis	2 (10.5%)	0 (0.0%)			2 (3.9%)
Schizoaffective Disorder	0 (0.0%)	4 (12.5%)			4 (7.8%)
Psychosis	1 (5.3%)	0 (0.0%)			1 (2.0%)
Other	1 (5.3%)	0 (0.0%)			1 (2.0%)
	Mean (SD)	**Mean (SD)**	**MWU**	**p**	**Mean (SD)**
Age	33.6 (8.24)	54.7 (8.44)	35.0	≤0.001	46.6 (13.28)

The survey data indicated positive change in nurses' knowledge, confidence, and other perceptions of person-side handover, after the implementation of the education and support package (Table 2). Statistically significant changes were identified for three items: perceived benefit to the consumer (55.2% vs 90%), confidence in conducting person-side handover (62.1% vs 97.6%), and the ability to ensure privacy and confidentiality (55.2% vs 92.7%).

Table 2 Affirmative responses regarding knowledge, confidence, and other perceptions, before and after implementation

	Before (n=29) N (%)	After (n=41) N (%)	X^2 (df)	p
Familiar with the practice of person-side handover	27 (93.1%)	40 (100.0%)	2.841 (1)	0.092
Involving the consumer in the handover process is beneficial to the consumer	16 (55.2%)	36 (90.0%)	10.983 (1)	≤0.001
Involving the consumer in the handover process is beneficial to the team	20 (69.0%)	34 (85.0%)	2.541 (1)	0.111
Confident in ability to carry out clinical handover with consumer participation	18 (62.1%)	40 (97.6%)	15.064 (1)	≤0.001
Adequate support and guidance for clinical handover with consumer participation	18 (62.1%)	33 (80.5%)	2.914 (1)	0.088
The handover process has assisted in consumer engagement	22 (81.5%)	37 (90.2%)	1.088 (1)	0.297
Can ensure consumer privacy and confidentiality in person-side handover	16 (55.2%)	38 (92.7%)	13.554 (1)	≤0.001
Handover is structured, timely, and addresses consumer and team need.	21 (75.0%)	37 (90.2%)	2.885 (1)	0.089

Responses to questions about the conduct of handover over the past week indicated positive change for most items (Table 3). Statistically significant differences were noted regarding the information provided and received in handover, and in the involvement of consumers and carers in the handover process. No change was noted in the time available to conduct effective handover, and a very small change was seen in the description of consumer needs during handover.

Table 3 The conduct of handover, before and after implementation

	Before (n=29) Mean (SD)	After (n=41) Mean (SD)	MWU	p
Handovers have contained all required information to enable you to address the needs of consumers in your care	2.7 (0.71)	3.1 (0.69)	430.5	0.025
Handovers have been accurate and there have been NO misinformation or errors in communication	2.4 (0.73)	3 (0.69)	359	0.002
Handovers have accurately described the consumer's needs	2.9 (0.58)	3 (0.74)	496	0.158
The consumer was present or offered to be present during handover	1.7 (0.77)	2.7 (0.78)	204	≤0.001
The carer or family member was involved or invited to participate in handover	1.6 (0.73)	2.2 (0.84)	362	0.002
The carer or family members' views or concerns were discussed in handover	2.5 (0.95)	2.9 (0.81)	438.5	0.069
There has been enough time to carry out clinical handover effectively	3.1 (0.82)	3.1 (0.76)	587	0.922

MWU = Mann-Whitney U test

Comments after implementation revealed how staff perspectives of this practice change changed over the course of the project. Before implementation, one respondent was concerned about consumers' involvement, suggesting that "often patients will not possess a mental state appropriate to be present during clinical handover". Others thought that consumer involvement was better placed in multi-disciplinary reviews, stating "I envision patients being present during the MDT will likely have a positive effect" and "MDT involvement may be more beneficial". One respondent noted that "we can improve in handover".

After implementation of the education and support package, there was a shift to a more consistently positive view, indicated by comments such as "this practice has been beneficial to both consumers and staff, all nursing care and handover has been transparent", "consumer participation is worthwhile and empowers the consumer", "handover at bedside is really helpful as it is what's needed for consumer care and minimise the risk", and "great

idea". There was recognition of a strong person-centred focus: "it must however be done in a sensitive way and be appropriate to where the consumer is on their recovery pathway" and "not all patients like to participate in bedside handover and at times can find it somewhat intimidating". One respondent suggested a "risk of triggering a negative response from consumers who may not have the insight necessary".

In contrast to the positive survey findings, very little documentation of person-side handover was found in the medical record audit. No such entries were identified in the medical records before implementation and only 3 of 28 files (10.7%) after implementation contained documentation of consumer involvement in handover.

Discussion

Initially, nurses in this study reflected the mental health and general literature regarding the perceived benefits of the consumer and carer involvement in handover, their capacity to ensure privacy and confidentiality, and their confidence to undertake the practice. Nurses' perspectives changed in four main areas: perceptions of consumer benefit, communication of information, the involvement of consumers and carers in handover, and confidence in adopting the practice. Comments suggested a broad positive shift in attitudes, as also noted by Olasoji et al. (2019).

Several key features of the education and support package may explain the changes, which are consistent with those seen by Miech et al. (2018), who noted that the modelling of senior clinicians, 'champions', at point of care were highly influential in successful implementations of practice change. In the present implementation, senior clinicians were supported by the consumer peer worker, a key feature of the package that added authenticity, and reinforced appropriate language and process at handover. These roles

were integral and provided leadership in education and ongoing support. The senior clinician role was to deliver the education, demonstrate the skills at point of care and to be a joint resource, with the consumer peer worker, for integration into practice. This was considered pivotal to this practice change and took advantage of positive prior relationships. That is, the existing relationship of the senior clinician and peer worker with the nursing team maximised engagement of the clinicians and provided relevance and rationale. Luz et al. (2019) suggest that staff feel more confident, and innovations spread if change is introduced with support from those who are trusted, known and respected. In this study, the champions were credible practitioners, well-placed to influence change. The central role of consumer peer workers emphasises collaboration between clinicians and consumers in treatment planning and delivery (Reid et al., 2018). The importance of support from these different sources is reinforced by Hahn et al. (2006) who propose that the delivery of an educational package in itself is not sufficient in effecting practice change amongst participants. They provide opportunity for both behavioural and attitudinal change (Curtis et al., 2017). Although attitude was not directly measured here, the altered behaviour may be indicative of such a change.

After participating in this program, nurses reported improvements in the accuracy and relevance of handover content, and a marked reduction in misinformation or errors in communication. This is consistent with suggestions that consumer involvement reduces miscommunication and errors and may lead to better care outcomes (Manias & Watson, 2014; Mardis et al., 2016). This potential impact on quality and safety is an important driver, further supported by Merten et al. (2017) who note that the consumer is the constant component of the care, while clinicians vary shift to shift. This also places consumer

appropriately at the centre of care and acknowledges that place as the source of definitive information.

The benefits of increased involvement for consumers are highlighted by Olasoji et al. (2018), particularly the support it provides to the provision of recovery-oriented care. This is further emphasised by Hu (2019) who found that consumers prefer this process of communication as they feel more involved in their care. Similarly, Manias and Watson (2014) suggest that the active involvement of the consumer, and if possible, their family member, provides a valuable opportunity for the discussion of care. This can greatly enhance the nursing team's understanding of the individuals care needs, which accords with the improvements in communication noted above.

Interestingly, some of the expected changes in practice did not occur. There was only a small increase in those that saw a benefit for the team, who believed that this augmented consumer engagement, that handover was structured and addressed needs, and that the consumers' needs were accurately described. It is important to note that these items were fairly positive before implementation, so that significant positive change was less likely to occur. Regardless, future exploration will provide clarification. There was also no change in the reported time available for handover, although nurses did indicate that they had sufficient time to conduct handover both before and after implementation. This is an important finding as it reasonable to expect a negative impact of a new approach to handover. Indeed, during consultation in the development of the education package, nurses suggested there was an issue of time and that this type of handover should only be carried out once a day, during the morning to afternoon handover. It is feasible that the combination of modelling and support from senior clinicians and consumer peer workers

was sufficient to ameliorate this issue, but no data were available to support this contention.

Despite the positive changes noted in nurse' perceptions of person-side handover, documentation was lacking. The survey results and comments suggest that person-side handover was taking place, but this was not reflected in the nursing notes. Indeed, as the survey showed significant improvement in consumer engagement in handover post implementation, it is not clear why this was not documented. One potential answer is that there is no specific or obvious method to document this engagement in the electronic medical record. Currently this record is structured around a suite of electronic forms aligned to the standardised clinical documentation modules and outcome measures across public mental health services in the jurisdiction of study (NSW Health, 2019). These modules were not developed with person-side handover in mind, and it is not clear that they are structured in such a way to be supportive of the practice. Further examination of how these forms support, or do not support, person-side handover is therefore warranted. There may be a requirement for modification or augmentation to the suite of forms, essential work if mental health services are to continue the path to effective partnerships with consumers in inpatient care. This is consistent with previous work that has identified structural or procedural challenges in electronic medical records (Akhu-Zaheya et al., 2018). It is also feasible that despite positive reports, nurses were not conducting person-side handover as frequently as indicated. This too deserves future examination, perhaps using observational or other techniques.

Limitations

Several limitations are evident in this study. The small sample size, omission of a unit designator in the survey, and lack of a validated instrument precluded unit comparisons or other analytical techniques, and future work should seek to address these issues. Also, while mental health consumers were strongly engaged in the development of the education and support package, and in the study overall, their views were not canvassed in the data collection. This is an obvious area for improvement and greater understanding. Finally, while implementation of the education and support package was well considered, it did not adopt an established implementation science model which may have helped identify other key components to address. For example, Curtis et al. (2017) note the many factors important for effective translation of evidence into practice. Future implementations will be improved by employing such a framework.

Conclusion

This study assessed the implementation of an education and support package for person-side handover in two mental health units. The development of the education and support package was informed by consumers, carers, and clinicians. The education package was delivered by senior clinicians and implementation was supported and modelled by senior clinicians and consumer peer workers at point of care. The study demonstrated positive change in nursing staff perceptions of person-side handover, and in nurses' confidence in incorporating it into their practice. There was a significant increase in consumer involvement, and a modest increase in carer involvement, in this new practice. Further work needs to be undertaken to understand the disparity between nurses' reported engagement with this practice, and the limited documentation. Person-side handover provides nurses with opportunities to work more collaboratively with consumers in a recovery-focused way

and supports the sharing of more comprehensive information which may enhance shared decision making and potentially improve safety.

This study provides a foundation for future work to embed and expand this important practice in mental health inpatient units in order to support collaborative care and shared decision-making processes, both tenets of recovery orientated practice that are central to mental health services. A focus on the ingredients that support the embedding of clinical practice that results in attitudinal change within the participants would be valuable to explore. This may result in a road map to support further practice change within clinical settings.

Conflict of Interest

No conflict of interest has been declared by the authors.

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