COLLABORATIVE HANDOVER

MENTAL HEALTH NURSING HANDOVER INVOLVING CLIENTS

IMPLEMENTATION AND EVALUATION REPORT

A REPORT TO THE OFFICE OF THE CHIEF MENTAL HEALTH NURSE (OCMHN) AT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Final report prepared for the Department of Health and Human Services on:

COLLABORATIVE HANDOVER

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IMPLEMENTATION AND EVALUATION

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PREAMBLE

Clinical handover is the effective transfer of professional responsibility and accountability for some or all aspects of care for a client, or group of clients, to another person or professional group on a temporary or permanent basis

'Collaborative handover' refers to bedside nursing handover that involves the client (known hereafter as client) in the process. Encouraging the adoption of collaborative handover will assist mental health services to meet the Australian Commission on Safety and Quality in Health Care's National Safety and Quality Health Service Standards (NSQHS) accreditation Standard 6, Clinical Handover; specifically, to address the criteria requiring services to establish 'mechanisms to include patients and carers in the clinical handover processes'[1].

Effective clinical handover reduces communication errors between staff and can improve client safety, client experiences, outcomes and care. Adverse events have been found to increase during the transfer of clients between units, physicians and teams. Client participation in handover can improve the effectiveness of the communication of information, and involving clients in their own care (particularly in decision making about their care) has been found to reduce the likelihood of an adverse event occurring.

Patient inclusive bedside nursing handover is common in other health settings such as emergency, midwifery and post anaesthetic care, but has not yet been adopted in mental health settings.

This resource has been developed to support best practice in the transfer of care between nursing shifts within the mental health adult acute inpatient setting. This project was a collaboration between Peninsula Health Mental Health Services and the Department of Health and Human Services. It draws on the ongoing work undertaken by hospital and community staff across many organisations, including the work on the National Safety and Quality Health Service Standards, namely Standard 6 relating to Clinical Handover.

Consistent with the objectives of contemporary and recovery-oriented nursing practice whereby an inclusive approach to handover and a collaborative approach to care delivery are seen as essential elements of mental health nursing, the Department of Health and Human Services and Peninsula Health are committed to provide evidence that will support the broader uptake of collaborative clinical handover across Victoria.

[1] Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 6: Clinical Handover (October 2012). Sydney. ACSQHC, 2012.

The objectives of the Collaborative Handover Project were to:

- Establish the evidence base for the use of collaborative handover in mental health inpatient settings
- Identify the barriers and enablers for client involvement in clinical handover
- Explore client and staff perceptions about client involvement in clinical handover
- Develop an educational program that provides clinicians with evidence based concepts that underpin effective clinical handover
- Develop implementation tools to assist mental health services with planning, implementation and reviewing collaborative handover
- Provide recommendations to the Office of the Chief Psychiatrist which would help inform the dissemination and broader uptake of collaborative handover across Victoria
- Develop evidence based practice guidelines for the implementation of collaborative handover in mental health settings

EXECUTIVE SUMMARY

This report presents the findings of an evaluation of data related to the implementation of collaborative clinical nursing handover on an Adult Acute Mental Health Inpatient Unit at Peninsula Health between 2015 and 2016.

This report supports best practice principles of collaboration whereby clients are active participants in the handover process and the transfer of care decision making processes and it provides solutions and recommendations to improve clinical handover practices between mental health nursing staff and clients who are accessing mental health inpatient units. For this to occur there needs to be strong leadership for a locally agreed vision that focuses on:

- Building **collaborative relationships**
- Establishing a **shared care culture locally**
- Developing **established processes** that promote structured meaningful communication

The outcomes of the evaluation have been developed in collaboration of the project team and include the following:

1. Involving clients in nursing handover is best practice in line with recovery oriented nursing practice
2. Stakeholder engagement in the process - This challenge acknowledges that effective partnerships are critical
3. Organisational leadership and governance - Leaders must advocate, facilitate and manage the change process to ensure objectives are met. Role modelling is needed from the Associate Nurse Unit Managers (ANUMs)
4. An effective information and communication strategy - To create a sustainable change in practice, health service systems must align with the collaborative handover vision. This needs to be communicated to all key stakeholders involved in the process in a timely manner
5. Staff training and feedback mechanisms - Learners to explore the systems and culture around collaborative clinical handover including the barriers and enablers in leading and improving systems and practices
6. Data to be utilised to inform practice change as well as measure progress. Evaluation methods (surveys, interviews and observational audits of practice)

7. Future planning will include the development of clinical practice guidelines to help inform the implementation of collaborative mental health nursing handover across Victorian mental health services. This could not be achieved within this current project

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DEFINITION OF TERMS

- Client - a person receiving mental health care. The term client, consumer and patients are used interchangeably during this report.
- Bedside Handover - common term used within general acute care setting. Refers to nursing handover that occurs by the bedside of the patient and in which the patient is involved in the process.

LITERATURE REVIEW

Clinical handover is an essential part of the nursing care delivery process including on an acute in-patient mental health unit. During the process of handover, there is a transfer of information and also responsibility and accountability for patient care from one health care professional, or team of professionals to another. The handover process has been noted to play a key role in maintaining patient safety as a large proportion of adverse events have been attributed to miscommunication during handover (Haig, Sutton & Whittington, 2006). In Australia, there are 7,068,000 clinical handovers every year in Australian hospitals (Manias et al, 2008).

Patient centred care is central to a safe and quality health care system (Australian Commission on Safety and Quality in Health Care, 2012). The involvement of patients or clients in the handover (bedside handover) of their care by nurses from one shift to the next has its origins in the evidence of nursing rituals, practice accountability, patient centred care and the quality and safety agenda and what patients want.

Past practice was modelled on nursing rituals of passing information 'one-way' from a senior nurse to a junior nurse, behind the closed doors of the nurses' office as though talking behind the back of the patient (Cahill, 1988). There are now many different forms of handover that are designed for different clinical settings and there is a trend towards patient involvement in the transfer of patient health information between two nurses and including the patient in the discussion (Bruten, 2016).

The engagement of patients in handover with nurses and other health professionals has been identified as reducing miscommunication in handover which has been associated with the reduction in adverse events (WHO, 2012; Anderson and Mangino, 2006). The involvement of the patient and their families in the care process (bedside handover) has also been reported as having the potential to reduce care fragmentation, readmissions and duplication of services (McMurray, Chaboyer, Wallis & Fetherson, 2010). Bedside handover has been noted to improve the conduct of nursing tasks and documentation (Kerr, Lu & McKinlay, 2013).

Contemporary nursing practice has been a more inclusive approach to handover where patients/clients are included as partners in their own care, capable of making important contributions to clinical decision-making and participating in their own care (McMurray, Chaboyer, Wallis &

Fetherson, 2011). This model of handover is common nursing practice in other settings such as midwifery, emergency department, ICU, some general ward settings and post anaesthetic care, and the aim is to enhance the quality and safety of the care provided as well as ensuring the patient/ client has a feeling of inclusion in the process. When patients/clients have input into clinical communications there is a reduced risk of fragmentation of care, miscommunication-related adverse events and greater likelihood of continuity of care (Rutherford et al. 2004).

The evidence describes what patients want: Information accuracy, timeliness and visibility. Patients need to feel they are having their needs met and they are involved. There is a need to feel there is continuity in care, that health professionals are talking to each other and client comments are valued.

In a study conducted in medical, surgical and midwifery wards of an Australian hospital by Lu, Kerr and McKinlay (2014) patients reported feeling empowered and contributing to error minimization when they were involved in nursing handover. Patients may observe that while health professionals declare individualised care as their focus, they operate within standardized routines, hierarchies and procedures (McMurray et al, 2010). This approach also addresses the rights of patients to be involved in their care with overall better care outcomes, reduced risk, greater satisfaction and at lower cost (McMurray, 2010, Anderson and Mangino 2006).

However, some patients do not want to be involved and take on an active role even though they don't want to, feeling the need to 'toe-the-line' (Waterworth and Luker, 1990). There needs to be respect for this decision to not participate. For others the clinical terminology is distressing (Martin et al, 2007).

Patients in the majority want greater involvement and need to be able to choose the extent (Brown, 2006, Greaves, 1999). Patients view the benefits as outweighing the slight risk of confidentiality loss and are not interested in what they might hear about other patients, not taking it in, and usually stop when they hear the muttering of a handover and walk away. They were also not concerned about what visitors might hear, since their clinical problem is long standing and visitors provide comfort.

Recovery-oriented nursing practice is an important concept in mental health care. Some of the key elements of contemporary understandings of recovery include the rights of the consumer to self-determination, freedom to live on their own terms, and to obtain support from professionals to help them achieve these goals and to facilitate community integration. A collaborative approach to care

delivery is seen as an essential element to recovery-oriented nursing practice (McKenna et al. 2014). Understanding a consumer's perception of their general health, risk factors and desire to change are also important steps on the road to recovery (Cleary, Horsfall, O'Hara-Adams & Hunt, 2013). Shared decision making is consistent with recovery oriented mental health care as the consumers are encouraged to be actively engaged in their own treatment and management (Drake, Deegan & Rapp, 2010).

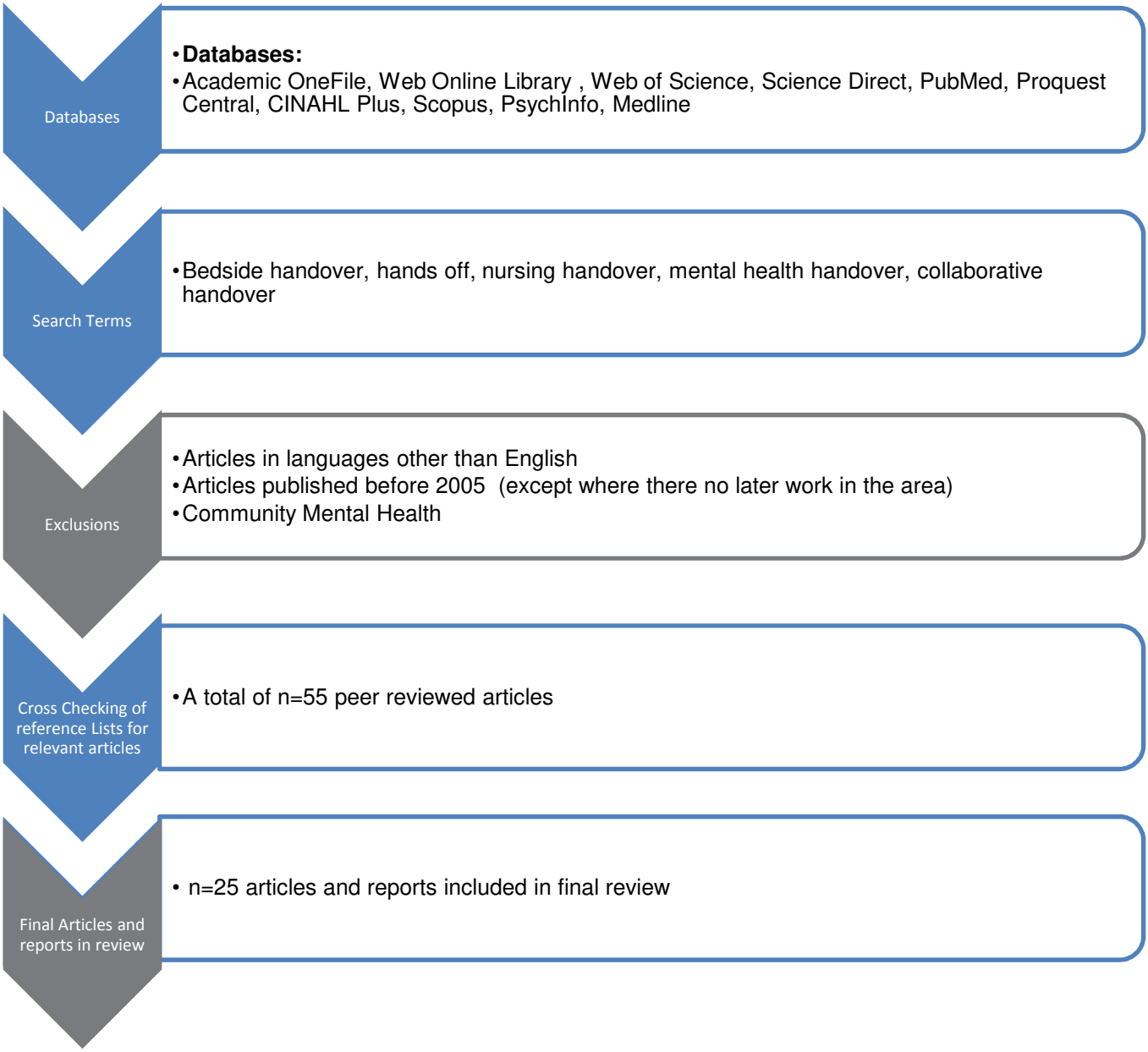
Several studies note that there was skill and confidence required in involving patients in handover and training should be provided and some standardisation may be required (Lu et al, 2014, Bruten et al 2016). A study by Waters et al (2015) in an in-patient psychiatric unit noted however that recording of patient preferences was low at 57% and this should guide our planning and practice. This evidence base for practice in recovery orientated practice is essential (Fisher and Happel, 2009, Cairns et al, 2013). Waters (2015) emphasized the importance of handover to care planning. The gap between theory and practice and familiarity with patients may be causes of reduced content at handover (McCloughen, 2008).

Even though some of the benefits of involving patients in the nursing handover has been widely reported in other areas of nursing care, the practice has not been embraced in the mental health inpatient settings. There has been no published work on the effectiveness of involving mental health clients in nursing handover on acute mental health inpatient units.

This current study seeks to examine the effectiveness of involving mental health clients in the nursing handover on an adult acute mental health inpatient unit.

Literature Search Strategy

Figure 1: Literature search strategy



METHODOLOGY

A system of mental health nursing handover was set up on an adult acute mental health inpatient unit in a Metropolitan Hospital in Victoria, Australia. The purpose of this project is to establish and evaluate the effectiveness of nursing handover involving clients (NHIC) on an adult acute mental health inpatient unit. The evaluation of the NHIC project was completed using a mixed method approach and data triangulation. The overall study was an exploratory descriptive study. Exploratory descriptive designs are useful when there is little known about the phenomena of interest (Brink & Wood, 2001). At the commencement of this project there was no published work on the effectiveness of client involvement in nursing handover in acute mental health settings.

PROJECT SETTING

The project was conducted on the Adult Acute Mental Health Inpatient Unit (2 West) at Peninsula Health. The Adult Acute Mental Health Inpatient Unit opened in 1991 delivering acute mental health care for people from ages 18-65. It is the only adult acute inpatient unit for the Peninsula catchment.

The unit has 29 beds with 23 of these beds in the Low Dependency Area, (LDA) and 6 in the Acute Management Area, (AMA). 2 West is a locked ward with a potential to be unlocked at certain times.

The unit provides specialist mental health services aimed primarily at people with serious mental health problems that have associated significant levels of disturbance and psychosocial issues due to their mental illness or disorder. Commonly these will be people with a diagnosis of a major mental illness such as schizophrenia or bipolar disorder, but will also include some people with other conditions such as severe personality disorder, severe anxiety disorder, or those who present in situational crisis that may lead to self-harm or inappropriate behaviour towards others.

STUDY PARTICIPANTS

Participants (clients) were recruited from the adult acute mental health inpatient unit of a major metropolitan hospital in Melbourne using a purposeful convenience sampling method. All of the participants were receiving care on the unit and had spent a minimum of five days on the unit prior to the interviews taking place. A broad range of samples (that is client diagnosis, age) was sought in order to gain deep insight into the subject matter, hence the use of purposeful sampling. The study

was promoted through the regular ward group facilitated by the Occupational Therapists (OTs). The Occupational Therapists were given information sheets outlining the study and interested participants were then approached by the researchers who provided further details about the study. Prior to interviews taking place written consent was sought from the participants. Interviews took place at the convenience of the participants.

The nurses involved in the project were all working on the unit as either permanent, part-time or bank nurses (the demographics of these nurses will be presented later in this report).

DATA COLLECTION

The interview schedule for the client interviews (Appendix B) was developed after consultations with an expert panel which included mental health nurses, the Consumer Consultant (a person with lived experience of mental illness, now employed by the health service), and nurse academics. The semi-structured interviews were guided by the interview schedule. Two members of the research team were involved in each interview. Interviews were digitally recorded and given to a professional transcriber. The interviews were transcribed verbatim thereby retaining the information from the verbal account and true to the original nature (Braun & Clarke, 2006).

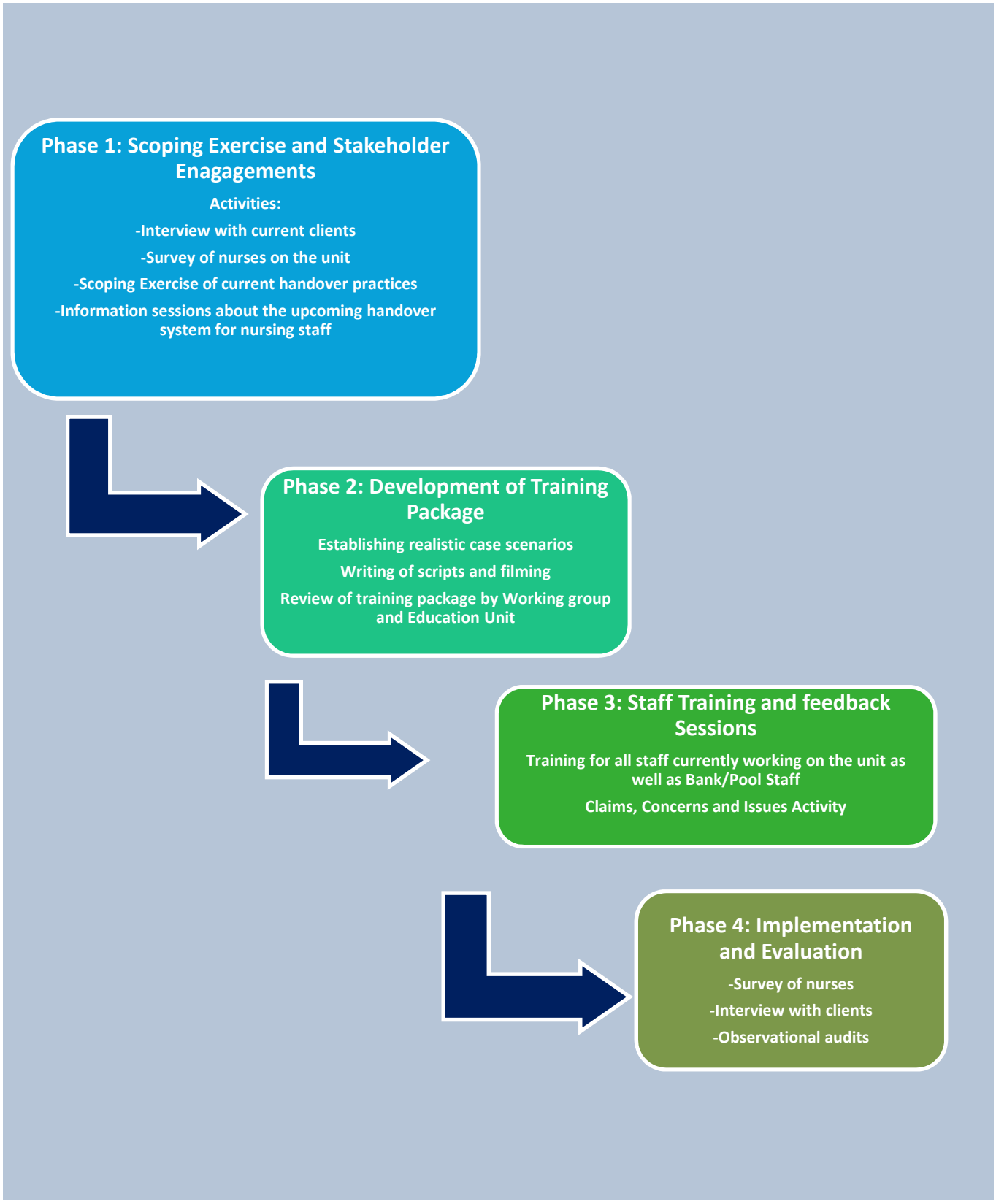
A 36-Item questionnaire (see Appendix C) was developed to capture the opinions of the nurses about proposed changes to the afternoon nursing handover process. There was no existing instrument to capture the views of mental health nurses about involving clients in nursing handover in the mental health setting. The construction of the questionnaire used in this project was informed by other studies in the literature that examined bedside handover in acute settings as well as the views of the expert panel overseeing the project.

The questionnaire consists of basic demographic questions and a 5-point Likert scale type questions (1=Strongly Agree; 2=Agree; 3=Unsure; 4=Disagree; 5=Strongly Disagree). The Likert scale questions covered the following categories: appropriateness of client involvement in mental nursing handover, confidence level of mental health nurses involving clients in handover and the impact on the therapeutic relationship. Other areas include, impact on client safety, alignment with mental health nursing practice, content of the nursing handover, time and workload as well as potential benefits.

OVERVIEW OF THE PROJECT

The establishment and evaluation of the effectiveness of the nursing handover project occurred in four phases (see Figure 2). Phase One of the project was a scoping exercise and engagement of key stakeholders around the establishment of a nursing handover involving clients (NHIC) system. Phase Two involved the creation of a training package for mental health nurses about how to deliver care NHIC. Phase Three was the delivery of training and it also involved staff feedback sessions about the implementation of NHIC. The last Phase (Phase Four) included the implementation and evaluation of the new handover system.

Figure 2. Overview of Project Phases



PHASE 1: Scoping Exercise and Stakeholders Engagement

The aim of Phase One of the project was to undertake a scoping exercise of the current practice of nursing handover on the unit as well as engage key stakeholders on their views about client involvement in nursing handover. Phase One involved a series of activities:

1. Constitution of a leadership and governance working group to oversee the implementation of the project
2. Baseline observation of current nursing handover timing
3. Review of any existing policy on nursing handover on the adult acute inpatient units
4. Ethical Approval to undertake research study sought
5. Interviews with current clients to explore their views about being involved in nursing handover as well as their understanding of the handover practice
6. Survey of mental health nurses currently working on the adult acute inpatient unit to seek their views about involving clients in the nursing handover. This survey will also be used to provide baseline data during the evaluation of the new handover process

Leadership and Governance Structure of the Project

A working party was constituted which also formed the research team to oversee the implementation of the new handover system also known as Nursing Handover Involving Clients (NHIC). The team consisted of the Nurse Unit Manager, Client Consultant, Clinical Practice Development/Improvement Nurse, Associate Nurse Unit Manager/Project Lead, and nurse academics from Monash University.

Mode of operation: Leadership and Governance Group

- The Working/Research Group provided leadership/oversight for the overall project
- The group met fortnightly to review project updates and trouble shoot where necessary
- Minutes were taken for record purposes
- The group reviewed the data collection tools, training materials and evaluation of the project
- Client participation was vital throughout the process with the Client Consultant playing an active role in project design and implementation

Senior Nurse Group (Associate Nurse Unit Managers)

Another group that was crucial to the implementation and ultimately success of the roll out of the Nursing Handover Involving Clients (NHIC) was the leadership team on the ward - the Associate Nurse Unit Manager (ANUM) group. Regular discussions and meetings were held by the Nurse Unit Manager to update on progress and seek feedback.

Baseline Observation of Current Handover Practice

Timing audits of current handover processes prior to the introduction of NHIC was carried out to help inform the project and provide baseline data about current practice on the unit. These audits were conducted by the Nurse Unit Manager and Clinical Practice Improvement Coordinator. They conducted timing studies to measure how long handover takes in minutes for a period of two weeks (14 days). The observations also included examining the content of handover.

1. The average time taken to conduct handover was 55 minutes
2. There were a number of interjections by staff during the process which prolonged the process
3. Information contained in the handover was at times contradictory, inaccurate or outdated
4. There was no opportunity for clients or carers to be involved in the handover process at all

Data Analysis: Interview with Clients

The interview transcripts from the client interviews were subjected to thematic analysis. The thematic analysis was undertaken through several iterations of each transcript using constant comparison to generate provisional themes. The thematic analysis was carried out according to steps suggested by Braun & Clarke (2006).

- Familiarisation with the data. The interview transcripts were read several times by three of the authors noting down their initial ideas
- Generating initial codes: Interesting features of the data were coded in a systematic way across the entire data set. The coding was done in line with the aim of the study. Notes were inserted into the transcripts

- Searching for themes: The codes were then collated into potential themes, data related to the potential themes were gathered
- Reviewing themes: A thematic map was generated
- Defining and naming the themes: Ongoing analysis was carried out to refine the specifics of each theme. There was an effort made to let the data suggest the names for the themes
- Producing the report: Selection of vivid, compelling extract examples, final analysis of selected extracts

As stated earlier, a purposeful sampling method was utilised to recruit clients into the study. A total of 11 participants (n=6 males and n=5 females) took part in the client interview. The principal diagnosis of the participants were n=6 Schizophrenia, n=4 Bipolar Affective Disorder and n=1 Major Depression (see table 1). All the participants were receiving care on the unit during the time of the interviews. The demographics of the clients represented a cross section of clients receiving care on the acute inpatient unit, i.e. diagnosis, age and gender.

Table 1. Sociodemographic Characteristics of the client participants pre-implementation (n=11)

Variable	(*n*=11)
Age (years)	
18-25	3
25-29	3
30-39	1
40-49	1
50-59	2
60-65	1
Gender	
Female	6
Male	5
Diagnosis	
Schizophrenia	4
Schizoaffective	2
Bipolar Disorder	3
Major Depression	2

Results

The analysis of the views and comments made by the participants during the interviews identified three themes related to nursing handover involving clients on the adult acute mental health inpatient

unit. These themes were: (i) *Behind closed doors*; (ii) *Being involved* and (iii) *Collaborative care*. These themes will now be discussed in the following section.

Theme 1: Behind Closed Doors

Participants were asked about their understanding of the reasons for handover and the handover process. They generally understood that the purpose was to share information about clients with the nurse on the next shift. The participants understood the need for nurses to discuss the progress of clients on the ward.

> *Really just a rundown of how the day's been and possibly what the client might be needing in the afternoon shift, so if they're coming off a morning shift and they will let the afternoon staff know perhaps what the clients might have requested, or need, or something (P4)*
>
> *How they're [client's] going and their needs passed over from one nurse to the next nurse so that the next nurse is able to do as good a job, or provide to the needs of the patients as best as they can. (P5)*

Participants were of the opinion that they had a role to play in the exchange of information during the nursing handover given the fact that the handover relates to their care. They would like to have a greater level of involvement in the process. They stated:

> *Obviously, we are the patients so we have a pretty big role ... We are the subject of the handover. (P6)*
>
> *Well, yeah. Because we're the people they're looking after. So at the end of the day, the reason they're here is to look after us. (P8)*

Participants also stated that they would like to know what the nurses had observed regarding their well-being and that such knowledge would clear any misconceptions about their treatment progress:

> *It would probably be good to hear what they've been observing as depending on where you are emotionally I guess, but yeah sometimes it would be good to know what they're thinking. (P4)*

Theme 2: Being Involved

This theme exposes the benefits that the participants see in their involvement in nursing handover. The subthemes that emerged within this theme were: (a) Clarifying issues and (b) Setting expectations.

Participants believed involvement in nursing handover will help clarify any issues or pre-conceived ideas based on incorrect observations or inferences about them that might influence their care. Participants also felt that being involved in the handover would provide them with the opportunity to know about the plans for them throughout the day.

So by being involved, I think that all of that confusion just goes away because you actually know what [is going on] - instead of wondering you actually know. (P1)

I'd be able to ask what the plan is for that day. Yeah - so you'd know straight at the start of the shift - what the plan is (P3)

Theme 3: Collaborative Care

The theme collaborative care refers to the level of involvement that participants want within the nursing handover. This theme examines the circumstances they would like to be involved with as well as the contribution of families and significant others. It reflects the co-construction of care. Participants noted that the handover should be private, goal directed and pertinent.

I think there would need to be definite procedures in place so that the participation is relevant to an outcome so it's not just back and forth…I think that you should have the opportunity to disagree and that be taken note of and handled at the end of the meeting or toward the end of the time… So in order to keep it contained within that hour then you would say that as you're taking your notes down on people, you say look, I hear what you're saying which is very important and we will discuss so we disagree on that. Yes, we disagree on point four, point one. (P1)

Participants believed that the client should speak first, followed by the nurse's observations and proposals. Importantly they warned about avoiding arguments with clients.

The participants also spoke about the role of their relatives and significant others in terms of their involvement in nursing handover. Most of the participants noted that it would be a positive thing to have their family members or significant others present during handover.

Participants felt that their family members often had a better knowledge of who they were and therefore would be able to contribute to advocate on their behalf especially in circumstances when they were not able to themselves.

If it is early in your treatment and you're actually not in a mental place during handover - if you did have your next of kin there or something, they could take on that role. If they know what's best for you, then if they could advocate for you during that involvement in handover - that would be good. (P2).

While the participation of family members was considered a positive thing, the participants stated that the patient should always be the person that would determine whether or not the family member should be included:

I guess there should be an option, the person should be given an option - good morning, this is - we're about to do handover. You could ask the patient, "are you happy with your family and friends - or your visitors being here, or would you prefer to do it privately"? (P4)

Participants identified a number of conditions for participation in handover. These address matters related to their mental state, differences of opinion and timing. Importantly they stated that they should have the choice to participate.

I think when I first came I probably wouldn't have wanted to be involved because I was particularly upset - I probably wouldn't want to hear what they were saying, what they were observing would've been really confronting to me, and made me feel very insecure. Yeah that's probably a point, when I wouldn't have wanted to be involved was early on (P4).

The issue of the duration of the process was also raised by the participants and they were concerned about possible increase in the demand for nurse's time. The participants felt nursing handover could drag on for a long time especially in situations where the client has many issues to discuss:

It could take up too much time if the client has got a lot they need to express during handover, or the observations made by the nurse that she needs to handover to the next shift nurse - if they were to upset the client or something - yeah, it could possibly create too much of a load for handover (P8).

Overall all the participants felt involving clients in nursing handover was a very positive step in the delivery of nursing care. Perhaps the overall feeling can be summed by this statement made by these participants:

The fact that we're having this discussion about clients being involved in handover just gives me great hope - I must say that this week has been a big one because two weeks ago when I came in here I held little hope for the whole world let alone for [ward name] so now I have hope (P1)

It's good. I really like the reforms in the mental health field. It's good. It's not being dictated at, its feeling more respected really. (P7)

Data Analysis of Nurses Survey: What The Nurses Said

A 36-Item questionnaire (see Appendix B) was developed to capture the opinions of the nurses about proposed changes to the afternoon nursing handover process. There was no existing instrument to capture the views of mental health nurses about involving clients in nursing handover in the mental health setting. The construction of the questionnaire used in this project was informed by other studies in the literature that examined bedside handover in acute settings as well as the views of the expert panel overseeing the project.

The questionnaire consists of basic demographic questions and a 5-point Likert scale type questions (1=Strongly Agree; 2=Agree; 3=Unsure; 4=Disagree; 5=Strongly Disagree). The Likert scale questions covered the following categories: appropriateness of client involvement in mental nursing handover, confidence level of mental health nurses involving clients in handover and the impact on the therapeutic relationship. Other areas include, impact on client safety, alignment with mental health nursing practice, content of the nursing handover, time and workload as well as potential benefits.

RESULTS

The result of the nurse's pre-implementation survey will be presented as combined data under Phase four of this report (page 25). For the purpose of this report key items of the nurse's survey will be presented. These includes responses related to; '**appropriateness of client involvement in nursing handover**', '**nurses confidence in handing over with client involvement**', '**impact of mental health nursing practice**', '**impact of nursing handover involving clients on time and workload of nurses**' and '**benefits of nursing handover involving clients**'. The pre and post intervention comparison is presented under the post evaluation results.

PHASE 2: Development of the Training Package

At the commencement of the project there were no existing training resources available to educate mental health nurses about client involvement in nursing handover. The project team deliberated on possible scenarios on the unit as a result of client involvement in the nursing handover.

Five case scenarios were formulated (Appendix G) that reflected the basic principles of nursing handover involving clients. The case scenarios demonstrated how to ensure the client's voice is heard, avoiding arguments and ways to work with clients that are unwilling to engage in the process. These scenarios were then developed into short video vignettes.

The Client/Consumer Consultant played a very active role in the critique of the case scenario's and the language used during the interactions. Part of the video scenes featured the Client/Consumer Consultant.

PHASE 3: Staff Training and Feedback Session (Claims, Concerns and Issues)

The training of nursing staff in preparation for the NHIC occurred over a period of three weeks. The training content and structure (see table 2) was designed to be delivered within one hour. During the training session a 'Claims, Concerns and Issues Activity' was also carried out. Claims, Concerns and Issues (CCI) derived from the Fourth generation evaluation work of Guba and Lincoln (1989). It seeks to peruse the opinion of stakeholders (in this case mental health nurses) who will be involved in and or affected by a proposed change. An engagement structure was established for the programme to maximise involvement and buy-in. This process facilitates a collaborative and democratic approach to practice development based on the principle of appreciative enquiry looking at what works and how to make it better. It enables individuals to raise awareness about what is happening around them, the role they play in what is happening around them, and ultimately encourages change (Manley et al 2008).

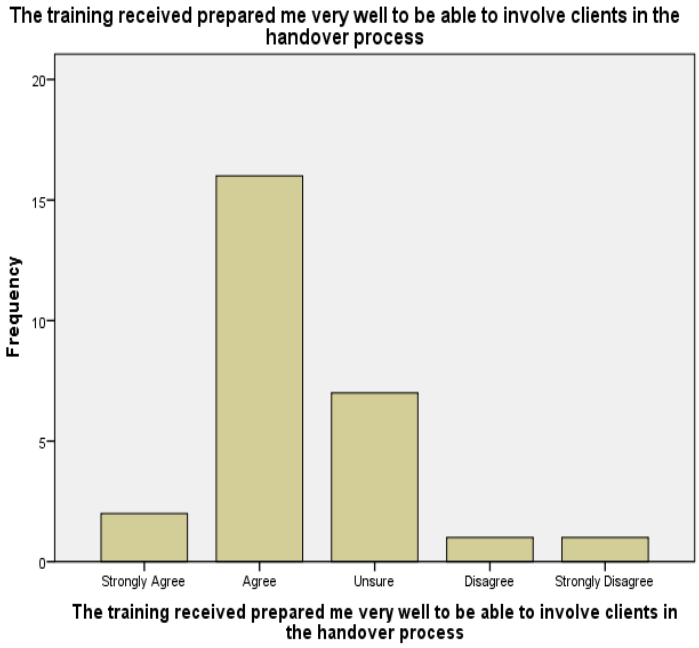
Table 2: Session Planner for Training Session

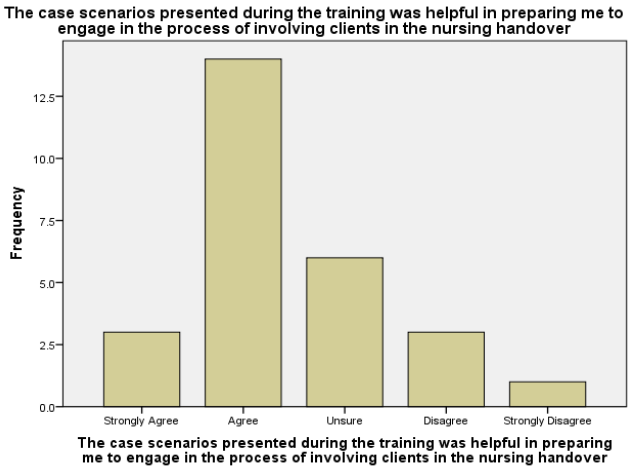
Facilitator:		
Target Audience: Registered & Enrolled Nurses working on 2 West		
Objectives and outcomes		
At the end of this session the participants will be able to:		
1. Have an overview of nursing clinical handover application and importance of collaborative clinical handover		
2. Develop skills around how to involve clients and significant others in nursing handover		
Equipment Needed: Computer with Video playing capabilities/Butchers paper/Markers		
Participants/Session: 8 -10 Participants		
Session Length: 1 Hour		
Time	**Topic**	**Main points/ Activity/Facilitator notes**
10mins	Why mental health clients should be involved in nursing handover? Overview of the handover process	Discussions among the group about any preconceived barriers related to clients' involvement in nursing handover Power point presentation about what handover is, recovery oriented practice…….

25 mins	**Video clips and discussions** (Video Length-Approx. 9min)	This video shows various scenarios of 'good' and 'not so good' practice relating to nursing handover involving clients. Participants are to reflect on the videos and identify key points **Case Scenario 1**: Breach of confidentiality Confidentiality issues - finding the space Ways of engaging client in conversation **Case Scenario 2**: Managing conflicts during handover What did Jess do well? What did Tony do well? What strategies did they use to avoid conflicts? (*Insert Client quote about arguments*) **Case Scenario 3**: Deteriorating handover What went wrong? Comments about body language What did the 2 nurses do? **Case Scenario 4**: Handover with carer present What was done well? How was the carer engaged? **Case Scenario 5**: When client does not want to be involved What was done well? What prompted the client to engage in conversation?
5 mins	Summary of Learning	Power point presentation about the 'how to' of nursing handover involving clients Handover print outs to participants (Cue Cards)
15 mins	CCI/Evaluation	

Evaluation of the Training by the Nurses

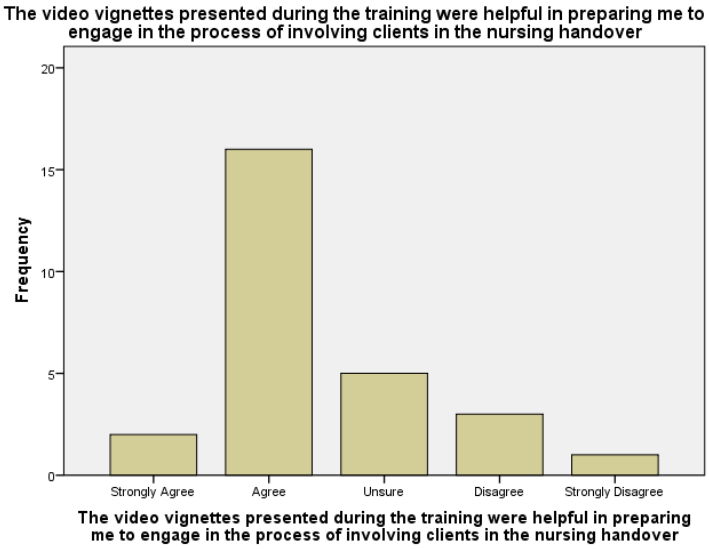
In relation to the training provided to nursing staff prior to the implementation of NHIC, 67% (n=18) believed it prepared them well for the process while 25% (n=7) were unsure and 8% (n=2) did not believe the training prepared them well for the implementation. In relation to the case scenario presented during the training, 63% (n=17) believed they were helpful, 22% (n=6) were unsure if they were helpful while 15% (n=4) did not believe they helpful.





The case scenarios presented during the training were presented in the form of video vignettes. A greater percentage of participants, 67% (n=18) believed the video was helpful in preparing them for

the engage in NHIC, 18% (n=5) were unsure while 15% (n=4) did not believe the videos were helpful. On the question of whether the training provided help increase the confidence of the participants to undertake NHIC, 67 %(n=18) were of the opinion that it did, 15% (n=4) remained unsure while another 18% (n=5) disagreed.



Information and Communications Strategy: 'The 12 days of Christmas Strategy'

One of the key information strategies utilised was a daily messaging that highlighted the key benefits and elements of NHIC. This was sent daily to all the staff as a countdown to implementation. An example of the message is displayed below:

Good morning all…

The 12 Days of Collaborative Clinical Handover - 3 days to go… Friday 5 February 2016

(To be sung to the tune of "The 12 Days of Christmas")

"On the **tenth day** of Collaborative Clinical Handover my true love discussed with me what the morning nurse should do before handover takes place…."

Day 10 - The role of the morning nurse

It is expected that the allocated morning nurse will have a discussion with the client about the process of the handover. Explain the process, seek the client consent. Handover period should not be the first time the client is hearing about the new system.

Today marks 3 days until the role out of client involvement in nursing handover on 2 West

The use of the "countdown" strategy meant that staff on the unit were engaged post training and were reminded of the how the new handover system was different from the usual practice.

New Handover Structure

After consultations with nursing staff about the proposed changes the morning and afternoon nursing handover was restructured to include the clients. In restructuring the nursing handover we also benchmarked with other Victorian Mental Health Services that have trialled client involvement in nursing handover. The researchers contacted representatives from three Metropolitan Hospitals that have a form of client involvement in nursing handover within their acute mental health units. The purpose of this was to gain an insight in regards to the processes from these other services and any challenges they may have encountered.

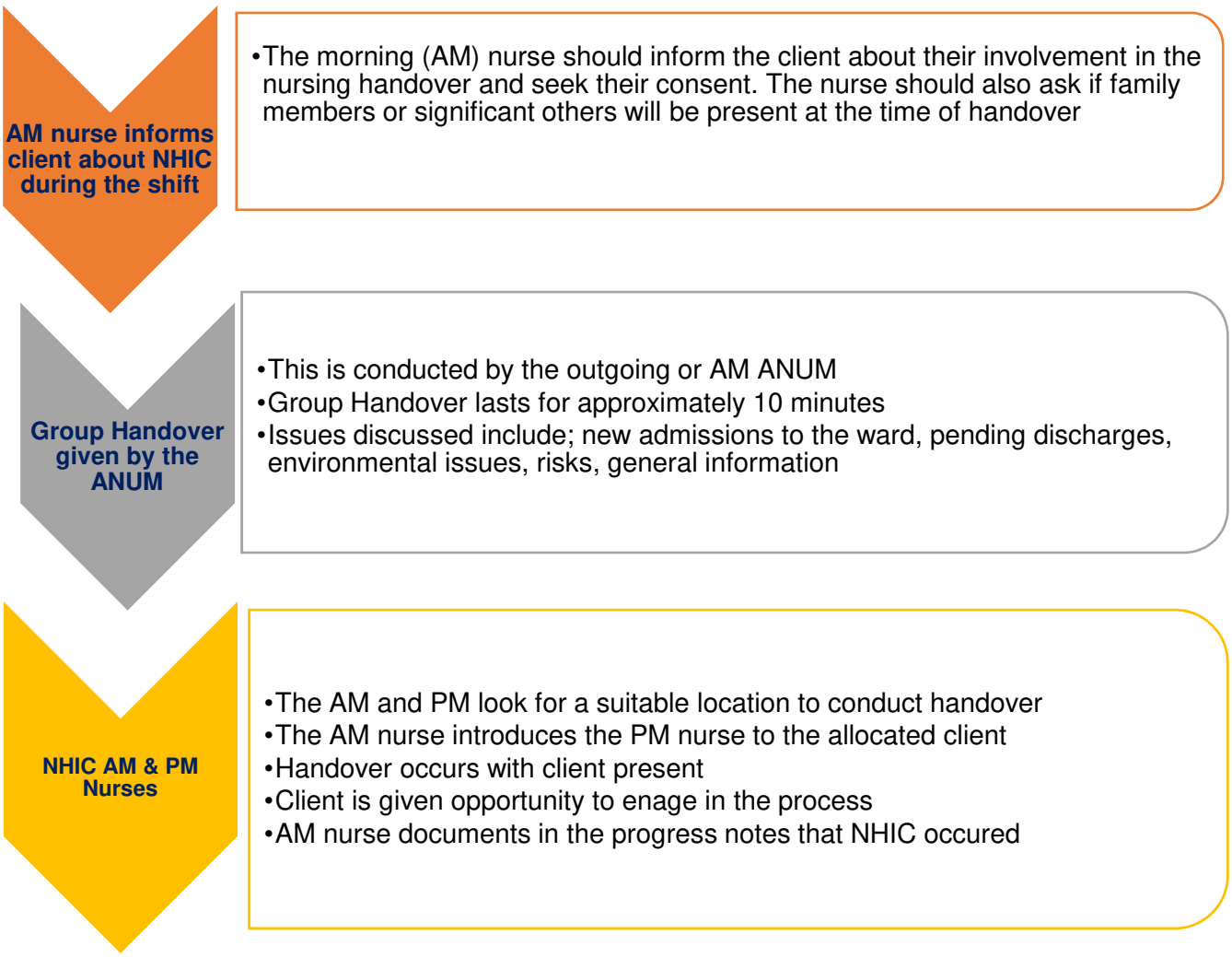


Figure 3: NHIC Process

PHASE 4: Post Implementation Evaluation

The post implementation of NHIC occurred after 3 months of the new system being in operation on the unit. The evaluation included the following:

- Interviews with clients on the unit
- Survey of nurses that have been part of NHIC
- Non-participant observational audits

The interview schedule for the client interviews (Appendix B) was developed after consultations with expert panel which included mental health nurses, the Consumer Consultant (a person with lived experience of mental illness, now employed by the health service), and nurse academics. The semi-structured interviews were guided by the interview schedule. Two members of the research team were involved in each interview. Interviews were digitally recorded and given to a professional transcriber. The interviews were transcribed verbatim thereby retaining the information from the verbal account and true to the original nature (Braun & Clarke, 2006).

A 40-Item questionnaire (see Appendix F) was developed to capture the opinions of the nurses about proposed changes to the afternoon nursing handover process. There was no existing instrument to capture the views of mental health nurses about involving clients in nursing handover in the mental health setting. The construction of the questionnaire used in this project was informed by other studies in the literature that examined bedside handover in acute setting as well as the views of the expert panel overseeing the project. The post implementation survey had additional questions to evaluate the impact of the training provided.

The questionnaire consists of basic demographic questions and a 5-point Likert scale type questions (1=Strongly Agree; 2=Agree; 3=Unsure; 4=Disagree; 5=Strongly Disagree). The Likert scale questions covered the following categories: appropriateness of client involvement in mental nursing handover, confidence level of mental health nurses involving clients in handover and the impact on the therapeutic relationship. Other areas include, impact on client safety, alignment with mental health nursing practice, content of the nursing handover, time and workload as well as potential benefits.

Data Analysis: Interview with Clients

As stated earlier, a purposeful sampling method was utilised to recruit clients into the study. A total of 10 participants (n=6 males and n=4 females) took part in the client interview. The principal diagnosis of the participants were n=2 Schizophrenia, n=3 Schizoaffective Disorder, n=2 Bipolar Affective Disorder, n=1 Borderline Personality Disorder and n=2 Major Depression (see table 3). All the participants were receiving care on the unit during the time of the interviews. The demographics of the

clients represented a cross section of clients receiving care on the adult acute inpatient unit, i.e. diagnosis, age and gender.

Table 3. Sociodemographic Characteristics of the client participants post-implementation (n=10)

Variable	(*n*=10)
Age (years)	
18-25	1
25-29	2
30-39	2
40-49	3
50-59	1
60-65	1
Gender	
Female	4
Male	6
Diagnosis	
Schizophrenia	2
Schizoaffective	3
Bipolar Disorder	2
Borderline Personality Disorder	1
Major Depression	2

The analysis of the views and comments made by the participants during the interviews identified three preliminary themes related to nursing handover involving clients on adult acute mental health inpatient. These themes were: (i) Good to know who to go to; (ii) Setting expectations and (iii) My voice was heard.

Theme 1: Good to Know Who to Go to

Participants were quite pleased that right from the start of the shift they knew who was going to look after them. This clarity according to the participants allayed their anxiety and apprehensions. Some of the participants recalled previous admissions to the unit and how nurses often sit in the handover room for an hour conducting handover. They felt this new system was much better than previous handover method.

> *It's good to know who to go to when you need help, good to put a face to the name. It sometimes gets chaotic over here. At least you know who is looking after you and you can go to see them (Par 1).*

Theme 2: Setting Expectations

The participants noted that the handover gave them the opportunity to be involved with the incoming and outgoing nurses. This made it possible to review or recap events of the day and then set expectations for the coming shift. The handover period also offered the opportunity to clarify issues.

Well one of - a few days ago I was having a really bad day and they [morning and afternoon nurses] came and introduced me to my afternoon nurse and said did I have any problems and I was like I'm feeling really down, is there anything you guys can do? They went and got me some medication and stuff so they act upon it. My afternoon nurse said I'll come and I will talk to you later and she stuck by that and actually came and got me and sat me down for a chat later on. (Par #2)

Then, on Sunday, it was looked at again and said no, you can't go down there, or something on that lines. So I find the way that sometimes the notes are interpreted can be different from nurse to nurse. When they both come together you are able to clarify some of these issues. (Par #4)

Theme 3: My Voice Was Heard

It was noted by most of the participants that they were given the opportunity to ask questions related to their treatment and it was a good feeling to get a sense that they were being listened to. This opportunity to contribute to their own care was of great importance to their overall sense of well-being.

Yes, they will often give you the opportunity to contribute and ask questions. I feel my voice is being heard well and truly (Par #1)

Yeah, they listen to everything you've got to say. Some are really good. They listen to everything (Par #3)

It makes you feel like you are not just a number but a person when they listen to you (Par #5).

Result of Mental Health Nurses Survey Pre and Post-Implementation

Pre-Implementation Survey

A total of n=45 nurses were working on the unit at the time of the survey. A total of n=36 (80%) nurses completed the **pre implementation survey**. There were n=29 (81%) females while n=7 (19%) were male. In terms of the age of the nurses, 17% (n=6) were aged 25 years and under, 17% (n=6) were between 26-35 years, while 36% (n=13) and 30% (n=11) were 36 - 49 years and 50 years and above respectively.

Regarding the qualification of the nurses, 39% (n=14) were Enrolled Nurses while 61% (n=22) were Registered Nurses. Among the Registered Nurses 36% (n=8) had a Masters qualification. 66% (n=18) of the nurses have worked 10 years and under in mental health setting while 33% (n=9) had worked 10 years or more in mental health.

Post Implementation Survey

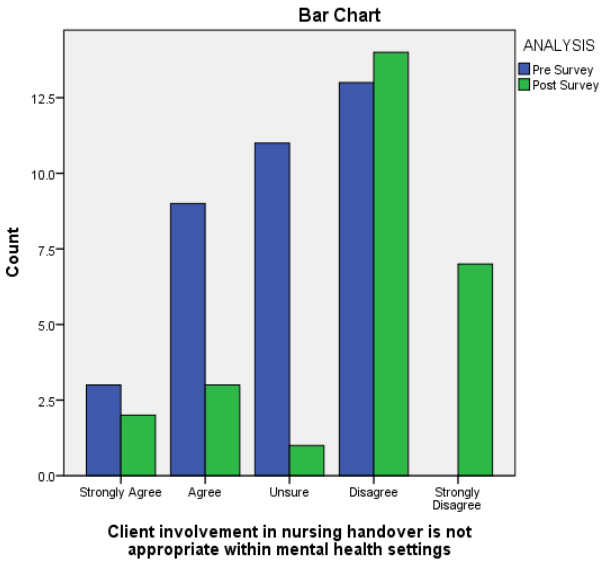
A total of n=41 nurses were working on the unit at the time of the survey. A total of n=27 (66%) nurses completed the **post implementation survey**. There were n=23 females (85%) while n=4 (15%) were male. In terms of the age of the nurses, 19% (n=5) were aged 25 years and under, 30% (n=8) were between 26-35 years, while 22% (n=6) and 30% (n=8) were 36 - 49 years and 50 years and above respectively.

Regarding the qualification of the nurses, 37% (n=10) were Enrolled Nurses while 63% (n=17) were Registered Nurses. Among the Registered Nurses 36% (n=7) had a Masters qualification. 50% (n=18) of the nurses have worked 10 years and under in mental health setting while 50% (n=18) had worked 10 years or more in mental health.

The following section presents findings from the Likert scale questions that were asked of the nurses. For the purpose of this report not all the item questions are included. The following items will be presented: *appropriateness of client involvement in nursing handover, nurses confidence in handing over with client involvement, impact of nursing handover involving clients on time and workload of nurses and benefits of nursing handover involving clients*.

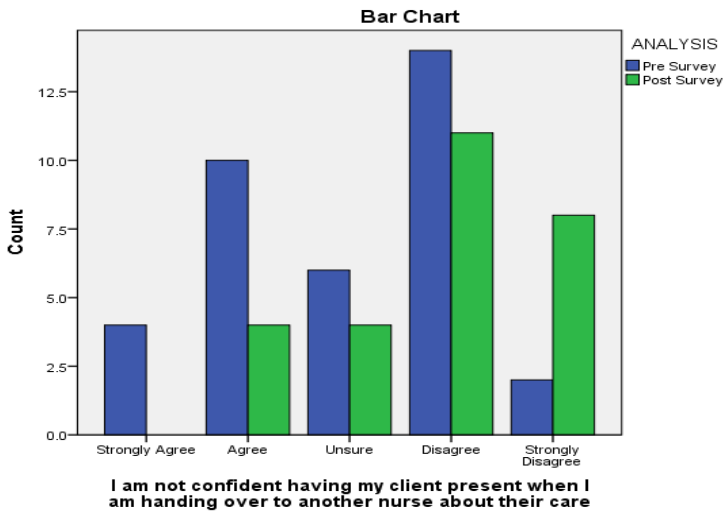
Appropriateness of Client Involvement in Nursing Handover

The nurses were asked about the appropriateness of involving mental health clients in the nursing handover. The Item question was: *Client involvement in nursing handover is not appropriate within mental health settings*. 33% (n=12) believed it was not appropriate in the pre-implementation group compared to 18% (n=5) post implementation who believed it was not appropriate.



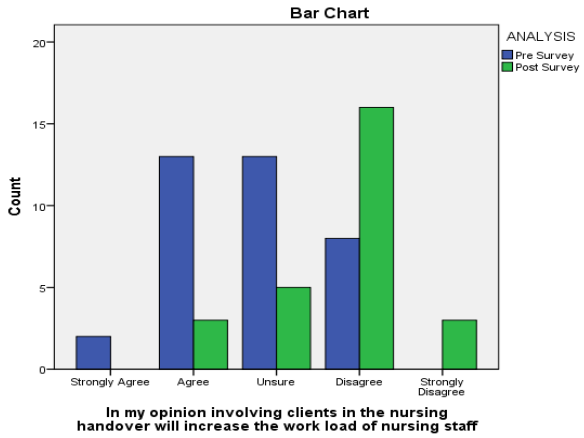
Confidence of Nurses Handing Over About Clients in their Presence

The nurses were asked about their ability to handover to their colleagues in the presence of the client's pre and post implementation of NHIC. *I am not confident having my client present when I am handing over to another nurse about their care*. In the pre-implementation, 70% (n=19) agreed with this statement, while post implementation 15% (n=4) stated they were not confident having the client during handover.

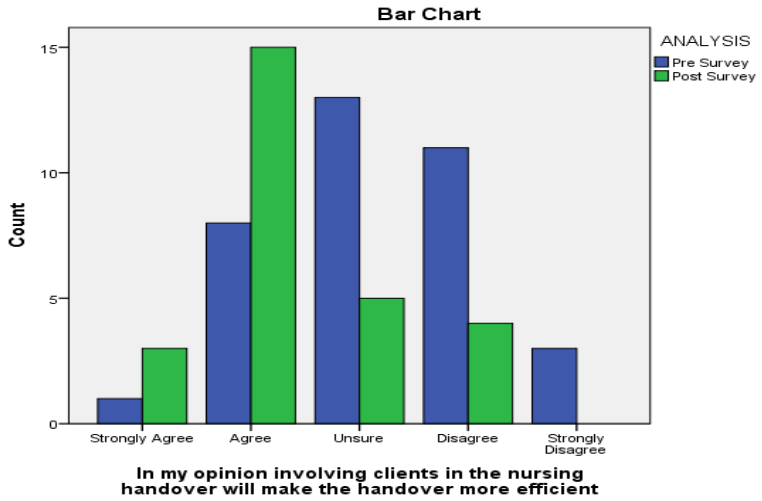


Impact of Nursing Handover Involving Clients on Time and Workload of Nurses

The impact that nursing handover involving client has or will have on the work load of nurses was examined. The question asked was, *In my opinion involving clients in the nursing handover will increase the work load of nursing staff* of which *42*% (n=15) respondents in the pre-implementation group agreed with the statement while 11% (n=3) in the post implementation agreed.



On the item about the efficiency of the handover process pre and post implementation of NHIC, only 25% (n=9) respondents in the pre-implementation group agreed compared to 64% (n=18) in the post implementation group.



From the pre and post implementation responses, there were initial concerns about the process on the part of the nurses, however once the process has occurred these concerns were less in nature.

Result of the non-participant observational audit

An observational audit tool was developed to capture real life experiences on the unit during NHIC. A total of n=22 observations of handover involving n=22 clients were carried out during the course of the project. Identified gaps in practice were fed back to the staff through emails. Key observations are as follows:

1. There was reduction in the period of handover from 60 minutes to 45 minutes thereby releasing time for care

2. Some clients were active and led the conversation (n=15 or 67%), but some others needed prompting (n=5 or 23%) and n=2 (9%) did not wish to participate in the handover process.

3. The location of the handover also varied. While majority (n=18 or 80%) of the handover took place in the client's bedroom or designated interview rooms, n=4 (20%) occurred in common areas such as dining room and outdoor areas.

DISCUSSION

There has been a wide acceptance of the need to include patients/clients in the nursing handover process and while this is now common practice in general acute wards (McMurray, Chaboyer, Wallis & Fetherston, 2009), the practice has not been well established within acute mental health inpatient settings. There is also no current literature on the practice of client involvement in mental health inpatient units.

This current study established a new system of nursing handover on an adult acute mental health inpatient unit at a Metropolitan Hospital in Melbourne, Victoria.

KEY OUTCOMES TO DATE

- Client involvement in nursing handover during one shift period on the ward now occurring
- Reduction in the time taken by nurses to complete handover thereby releasing more time for care
- Positive feedback from client interviews in regards to collaborative handover process
- Delivery of mental health nursing care in line with recovery oriented care principles

LIMITATIONS

This current study was a pilot study on the process involved in the implementation of nursing handover involving clients on an adult acute inpatient unit. The project occurred in a single mental health unit and therefore the results cannot be generalised. The project does offer insight into the issues that surround the implementation of NHIC. The principles can be adopted by other mental health units looking to establish NHIC. The project was also limited to one change over shift i.e. afternoon shift change over.

RECOMMENDATIONS

The following are some interim recommendations

1. Involving clients in nursing handover is best practice as it aligns with recovery oriented nursing principles
2. Stakeholder engagement in the process - This challenge acknowledges that effective partnerships are critical
3. Organisational leadership and governance - Leaders must advocate, facilitate and manage the change process to ensure objectives are met

4. Effective information and communication strategy - To create a sustainable change in practice, health service systems must align with the collaborative handover vision
5. Staff Training and feedback mechanism - Learners to explore the systems and culture around collaborative clinical handover including the barriers an enablers in leading and improving systems and practices
6. Data to be utilised to inform practice change - Evaluation methods (surveys, interviews and an observational audit)
7. There is a need to run other pilot replica studies at other acute mental health inpatientmunits in Victoria so as to have more robust data

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Appendix A: Ethical Approval for Study

Premier's Award Metropolitan Health Service of the Year 2007, 2009

RESEARCH PROGRAM

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Aged Care, Rehabilitation & Palliative Care Services

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HUMAN RESEARCH ETHICS COMMITTEE | Low Risk Research Subcommittee

Full Approval

7 August 2015

Dr Michael Olasoji
Mental Health Unit
Peninsula Health
PO Box 52
FRANKSTON VIC 3199

Dear Mr Olasoji

PROJECT: LRR/15/PH/13
TITLE: The effectiveness of nursing handover involving clients on an adult acute mental health in-patient unit

Thank you for submitting the above project which was first considered by the Peninsula Health Low Risk Research Subcommittee on Tuesday 9 June 2015 and with a revised application considered on Tuesday 14 July 2015 in accordance with the National Statement on Ethical Conduct in Human Research (2007). Following submission of required amendments approval is now granted.

The documents reviewed and approved include:

Application (NEAF):	9 June 2015
VSM:	26 June 2015
Protocol:	29 June 2015
Participant Information and Consent Forms:	
Client:	3 August 2015
Nurses:	3 August 2015
Research Tools:	
Survey Nurses Pre Implementation:	Version 3: 4 August 2015
Survey Nurses Post Implementation:	Version 3: 4 August 2015
Focus Group Questions Clients Pre Implementation:	Version 2: 29 June 2015
Focus Group Questions Clients Post Implementation:	Version 2: 29 June 2015
Focus Group Questions Nurses:	Version 1: 29 June 2015
E-mail to Nurses Survey:	Version 2: 3 August 2015
E-mail to Nurses Focus Group:	Version 2: 3 August 2015
Advertisement Clients:	Version 3: 3 August 2015
Advertisement Nurses Survey:	Version 3: 3 August 2015
Advertisement Nurses Focus Group:	Version 1: 22 July 2015
Flow Chart :	Version 1: 29 June 2015

Please note the following requirements of the Peninsula Health HREC:

1. The principal investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
   - any serious or unexpected adverse events
   - unforeseen events that might affect continued acceptability of the project.

2. Proposed changes to the research protocol, conduct of the research, or research completion date will be provided to the Low Risk Research Subcommittee (LRRS) for review in the specified format.

3. The Low Risk Research Subcommittee will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.

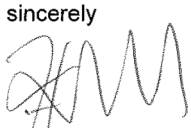
4. The principal investigator will provide an annual report to the LRRS and at completion of the study a final report, in the specified format.

Should you have any queries about the HREC's consideration of your project please contact Ms Lee-Anne Clavarino, Manager, Research Program. Details of review processes and guidelines are available on the Peninsula Health website http://www.peninsulahealth.org.au/research-and-education/human-research-ethics-and-governance/.

Please quote the Peninsula Health Project Number in all correspondence.

The Committee wishes you every success in your research.

Yours sincerely



Dr Fergus Kerr
Executive Director Medical Services
Quality and Clinical Governance

Executive Sponsor Research

Appendix B: Interview Schedule for Clients Pre-Implementation and Post Implementation

PRE-IMPLEMENTATION CLIENT INTERVIEW SCHEDULE

Interview Questions

1. What is your understanding of nursing handover on the ward?
2. What is your understanding of the purpose of current nurse to nurse handover on the ward?
3. How do you feel about the nurses including you in their handover in the future?
4. As a client on the ward, do you feel you have a role in the nurse handover?
5. What are the issues you would like to bring up if you were involved in the nursing handover?
6. Would there be any circumstance where you would not want to be involved in the nursing handover? If so, what circumstance?
7. How do you think your family members or loved ones can contribute to the nursing handover if they were present? Would you like family members to be involved?
8. In your opinion, what are positives of involving clients in the nursing handover?
9. In your opinion, what are negative consequences of involving clients in the nursing handover?
10. Do you think that the involving you in the nursing handover on the ward may compromise your privacy and confidentiality?
11. Any other comments?

Appendix C: Pre - Implementation Survey of Nurses

Demographics

A1: Age

☐ 25 years or under ☐ 26-35 years ☐ 36-49 years ☐ 50 years or above

A2: Gender

☐ Female ☐ Male ☐ I'd rather not say

A3: The highest degree or level of education you have completed

☐ Diploma ☐ Bachelor's degree ☐ Master's degree ☐ PhD ☐ Others (Please specify……..)

A4: Years in the nursing field:

☐ 2 years or less ☐ 3-5 years ☐ 6-10 years ☐ 11-20 years ☐ 21-30 years ☐ More than 30 years

A5: Have you ever worked in a mental setting where clients were involved in the nursing handover?

☐ Yes ☐ No

Tell us what you think,

Please tick the most correct answer

PRE-IMPLEMENTATION QUESTIONNAIRE

Effectiveness of nursing handover involving clients on an acute mental health inpatient unit
Peninsula Health Mental Health Services- 2West

ITEM	1	2	3	4	5
	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
Appropriateness in mental health					
A6. Client involvement in nursing handover is not appropriate within mental health settings					
A7. Mental health clients are unable to participate in nursing handover due to the language used in the process					
A8. Mental health clients are unable to participate in nursing handover due to the nature of mental illnesses.					
Confidence					
A9. I am not confident having my client present when I am handing over to another nurse about their care.					
A10. I will not receive correct information from the clients regarding their mental state.					
A11. I am confident I will receive accurate information from the clients regarding their mental state.					
Therapeutic relationship					
A12. Client participation in the handover will help to establish the therapeutic relationship with the client for the shift.	SA 1	A 2	U 3	D 4	SD 5
A13. Participation of clients in the nursing handover will hinder the nurse-client therapeutic relationship					
A14. Participation of clients in the nursing handover process will enhance the nurse-client therapeutic relationship					

Client Safety					
A15. Client participation in the nursing handover can have negative consequences to their overall mental state.					
A16. It will not be appropriate to discuss risk issues about the client in their presence.					
A17. Client participation in the handover will increase the risk of aggression.					
A18. Client participation in the handover will decrease the escalation of aggression					
Nursing Practice					
A19. Participation of the clients in the nursing handover process upholds the principles of recovery oriented practice					
A20. Participation of clients in the nursing handover process will promote shared decision making.					
A21. Involving clients in the handover process may hinder my ability to provide care for the client.					
A22. Involving clients in the handover process can assist in setting mutual goals for the shift duration with the client.					
Contents of nursing handover	SA 1	A 2	U 3	D 4	SD 5
A23. It will not be appropriate to discuss the client's mental state in their presence most of the time.					
A24. It will be appropriate to discuss clients' mental state in their presence at all time.					
A25. Involving clients in the handover process can help clarify client expectations					
A26. Involving clients in the handover process has the potential to reduce miscommunication of information					
A27. The mental health ward environment is not conducive to accommodate client involvement in the nursing handover					
A.28 Involving clients in the nursing handover process may compromise their privacy and confidentiality.					
A29. In my opinion involving clients in the handover process may lead to important clinical information being overlooked.					
Time & workload	SA 1	A 2	U 3	D 4	SD 5
A30. In my opinion involving clients in the handover will prolong handover process unnecessarily.					
A31. In my opinion involving clients in the handover will make the handover more efficient.					
A.32. In my opinion involving clients in the handover will increase the work load of nursing staff.					
Benefits	SA 1	A 2	U 3	D 4	SD 5
A33. There is no possible benefit in including clients in the nursing handover process.					
A34. Having family members or relatives of the clients on the ward at the time of handover will make client involvement in the handover process difficulty.					
A35. There are potential benefits to having family members or relatives present if clients were to be involved in the nursing handover process.					
A.36. I am in favour of clients' involvement in nursing handover process?					

Appendix D: Observational Audit Tool

Nursing Handover Involving Clients Audit Tool (2 West)

Item		
Date of Audit:		
Client UR:		
AM Nurse:		
PM Nurse:		
Duration of Group handover:		
Duration of Individual handover:		
Location of Individual handover		
Was client aware of involvement in handover prior?	Yes	No
Did Nurses seek consent? (Please circle)	Yes	No
Was carer/relative present? (Please circle)	Yes	No
Was consent for carer involvement sought? (if applicable)	Yes	No
Did the client participate in the Handover discussion?	Yes	No
Summary of issues discussed: (Examples: Leave, MSE, Reviews, Medications, discharge, etc)	1. _____ 2. _____ 3. _____ 4. _____ 5. _____	
Was Client Involvement in Handover documented?	Yes	No
Auditor Initials:		

Appendix E: Interview Schedule for Clients post-implementation

	Questions
1	Can you please state how many days you have been on the ward
2	Can you recall how many times you have been involved in the nursing handover during your stay? (If not every day, please state the reasons why this did not occur)
3	What do you think about mental health nurses involving you in the shift-to-shift handover?
4	During the nursing handover process, did you feel your voice was heard? If so what aspects. If not why?
5	Did you believe involving you in the nursing handover make a difference to the care you received?
6	Did your allocated nurse seek your permission before involving you in the handover?
7	From your perspective, what are some of the benefits of being involved in handover?
8	What are some of the limitations of being involved in nursing handover?
9	Any other comments?

Appendix F: Post Implementation Survey of Nurses

Demographics

A1: Age

☐ 25 years or under ☐ 26-35 years ☐ 36-49 years ☐ 50 years or above

A2: Gender

☐ Female ☐ Male ☐ I'd rather not say

A3: The highest degree or level of education you have completed

☐ Diploma ☐ Bachelor's degree ☐ Master's degree ☐ PhD ☐ Others (Please specify……..)

A4: Years in the nursing field:

1 ☐ 2 years or less 2 ☐ 3-5 years 3 ☐ 6-10 years 4 ☐ 11-20 years 5 ☐ 21-30 years 6 ☐ More than 30 years

A5: Have you ever worked in a mental setting where clients were involved in the nursing handover?

1 ☐ Yes 2 ☐ No

Tell us what you think,

Please tick the most correct answer

POST-IMPLEMENTATION QUESTIONNAIRE

Effectiveness of nursing handover involving clients on an acute mental health inpatient unit
Peninsula Health Mental Health Services- 2 West

ITEM	1	2	3	4	5
	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
Appropriateness in mental health					
A6. Client involvement in nursing handover is not appropriate within mental health settings					
A7. Mental health clients are unable to participate in nursing handover due to the language used in the process					
A8. Mental health clients are unable to participate in nursing handover due to the nature of mental illnesses.					
	SA 1	A 2	U 3	D 4	SD 5
Confidence					
A9. I am not confident having my client present when I am handing over to another nurse about their care.					
A10. I believe clients withheld information regarding their mental state from me.					
A11. I am confident I received accurate information from the clients regarding their mental state.					
Therapeutic relationship					
A12. Client participation in the handover helped to establish the therapeutic relationship with the client for the shift.					
A13. Participation of clients in the nursing handover has hindered the nurse-client therapeutic relationship					
A14. Participation of clients in the nursing handover enhanced the nurse-client therapeutic relationship					
Client Safety					

A15. Client participation in the nursing handover had negative consequences to their overall mental state.					
A16. It was not appropriate to discuss risk issues about the client in their presence.					
A17. Client participation in the handover increased the risk of aggression.					
A18. Client participation in the handover helped to decrease client agitations					
	SA 1	A 2	U 3	D 4	SD 5
Nursing Practice					
A19. Participation of clients in nursing handover upholds the principles of recovery oriented practice					
A20. Participation of clients in nursing handover promoted shared decision making.					
A21. Involving clients in the handover hindered my ability to provide care for the client.					
A22. Involving clients in the handover assisted in setting mutual goals for the shift duration with the client.					
Contents of nursing handover					
A23. It was not appropriate to discuss the client's mental state in their presence most of the time.					
A24. It was appropriate to discuss clients' mental state in their presence at all time.					
A25. Involving clients in the handover process helped clarify client expectations					
A26. Involving clients in the handover process assisted in reducing miscommunication of information					
A27. The mental health ward environment is not conducive to client participation in the nursing handover					
A.28 Involving clients in the nursing handover process compromised their privacy and confidentiality.					
A29. In my opinion involving clients in the handover process has led to important clinical information being overlooked.					
	SA 1	A 2	U 3	D 4	SD 5
Time & workload					
A30. In my opinion involving clients in the handover has prolonged handover process unnecessarily.					
A31. In my opinion involving clients in the handover has made the handover more efficient.					
A.32. In my opinion involving clients in the handover has increased the work load of nursing staff.					
Benefits					
A33. There was no benefit in including clients in the nursing handover process.					
A34. Having family members or relatives of the clients on the ward at the time of handover made client involvement in the handover process difficult.					
A35. There were benefits in having family members or relatives present during the nursing handover process.					
A36. I am in favour of clients' involvement in nursing handover process.					
Adequacy of Training Received					
A37. The training received prepared me very well to be able to involve clients in the handover process.					
A38. The case scenarios presented during the training was helpful in preparing me to engage in the process of involving clients in the nursing handover.					
	SA 1	A 2	U 3	D 4	SD 5
A39. The video vignettes presented during the training were helpful in preparing me to engage in the					

process of involving clients in the nursing handover					
A40. The training increased my confidence to involve clients in the handover.					

Thank you for your participation in this study. Kindly place the completed survey in the sealed box provided in the staff room.

Please see contact details in the Participant Information and Consent Form if you have any questions.

Appendix G: Script for Case Scenarios

CASE SCENARIO 1 DETAILS:	**No client involvement & breach of confidentiality**
PARTICIPANTS:	**Stephanie (Client), Nurse 1 (AM Nurse), Nurse 2 (PM Nurse)**
SETTING:	**Handover occurring in shared room with co-client present.**
BACKGROUND INFORMATION ABOUT THE PATIENT (AVAILABLE ON THE HANDOVER SHEET)	
51yo lady in 21years same sex relationship with supportive partner. Mother of three adult children, BIB acute team to ED with partner after referred by GP due to increased suicidal thoughts with plan to OD or jump in front of a car. Hx of depression, noncompliant with her medication, recently re-commenced on 'Lovan'. 6-8/52 moved back from QLD, Sexually abused at the age 10-14 by older brother and witnessed younger brother getting sexually abused by same older brother. Mother physically abused. 2nd husband physically abused.	
24 HOUR HANDOVER (AVAILABLE ON HANDOVER)-	
Overweight lady with short grey hair + glasses, very teary, upset, feels would be better off dead as wouldn't be in pain anymore. Depressed, NFTD, Ongoing suicidal ideations, reasonable insight. Once awake became tearful and wants to die, requested for PRN. Settled with 2mg Lorazepam. Needs UDS. Fasting bloods this morning.	
NHIC WITH STEPHANIE IN ATTENDANCE	
Nurse 1: Good afternoon Stephanie, Remember we discussed about your involvement in the handover. I would like to introduce **Nurse 2:** Who will be looking after you this afternoon. Are you still happy to be involved in the handover? **Stephanie**: Yes **Nurse 1:** Hi Melanie (Stephanie's roommate), we are just here to do the handover with Stephanie **Nurse 1:** (Nurse 2) Stephanie has been upset, feels would be better off dead as wouldn't be in pain anymore. She is feeling depressed, she has no formal thought disorder and has ongoing suicidal ideations, she has reasonable insight. **Nurse 1 & Nurse 2:** Thank you Stephanie for your time will catch you later.	
AM Nurse:	**PM Nurse:**

CASE SCENARIO 2 DETAILS :	**Multiple care needs/request & Arguments**
PARTICIPANTS:	**Trevor (Client), Nurse 1 (AM Nurse), Nurse 2 (PM Nurse)**
SETTING:	**Handover occurring in Interview Room.**

BACKGROUND INFORMATION ABOUT THE CLIENT (AVAILABLE ON THE HANDOVER SHEET)

48 year old single male lives with mum. Well known to our services. Last admission Feb 2015. Dx of SAD, managed by community team. Concerned about his mental status. Poor sleep, increased sexual themes, believing he is Jesus Christ. Hx trying to physically assault his mum when unwell.

24 HOUR HANDOVER (AVAILABLE ON HANDOVER)

Poor ADLs, unkempt, superficially co-operative. Distracted +++, Argumentative, difficult to interrupt, Labile, agitated at times. Mood as good. Believes he is 'Stephan' descended from heaven. Also identifies self as 'Jesus Christ the Messiah'. Auditory hallucinations of Stephen. Overly responding to A/H. Flight of ideas. States circumstances surrounding this admission were a mistake, just wanting to be discharged. Poor insight. Impaired judgement. Needs UDS. S.V Levels and other bloods this morning.

NHIC WITH TREVOR IN ATTENDANCE

Nurse 1: Good afternoon Trevor, remember we discussed about your involvement in the handover earlier this morning. I would like to introduce (Nurse 2) who will be looking after you this afternoon. Are you still happy to be involved in the handover?
Trevor: Yes, absolutely.
Nurse 1: So, Trevor can you just let us know how you have been feeling today?
Trevor: I am feeling fine, you guys know that there is nothing wrong with me and you keep holding me in this place. Can I have leave now from the ward?
Nurse 1: Thanks Trevor we'll discuss your leave later but remember what you were telling me in the morning about being Stephan and Jesus and that you were hearing voices of, you had flight of ideas ……
(Trevor Interrupts)
Trevor: Can we just talk about my leave…., just to let you know I will not be taking that medication so you can tell the doctor to shove it ********.
Nurse 2: Well, Trevor, you are unwell and you need the medication, this may…..
(Trevor interrupts, swears and now getting agitated)
Nurse 1 & Nurse 2: (*Attempts to deescalate and mention prospects of prn medication*)

AM Nurse:	**PM Nurse:**

CASE SCENARIO 3 DETAILS	Not willing to engage in process
PARTICIPANTS:	Amanda (Client), Nurse 1 (AM Nurse), Nurse 2 (PM Nurse)
SETTING:	Handover occurring in client's single room

BACKGROUND INFORMATION ABOUT THE CLIENT (AVAILABLE ON THE HANDOVER SHEET)

56yo Female, long history of schizophrenia, T/f St. Luke's hospital after her friend brought her to St. Luke's as she believes St. Luke is the best hospital and has a negative view of Frankston hospital. Friend reported that Patient had OD on 2g of Effexor. On admission: BIBA initially refused to get out of the stretcher. Then bolted for female corridor, closed fire door and struck out at a female staff. When staff approached she threw herself on the floor. All the time remind non-verbal. Transferred to AMA. Not engaging with staff. Not eating or drinking.

24 HOUR HANDOVER (AVAILABLE ON HANDOVER)

Nursed in AMA initially mute 2mg of IMI lorazepam given under planned code grey, afterwards, began eating and drinking, stating her mood is good and denying any ideas of self-harm. Moved to LDA, remains withdrawn , but noted some improvement, when reviewed by HMO , denies risk to self, concerns centred around friend, Caroline who she feels has been taking advantage of her

NHIC WITH AMANDA IN ATTENDANCE

Nurse 1: Good afternoon Amanda, remember we discussed about your involvement in the handover earlier this morning. I would like to introduce (Nurse 2) who will be looking after you this afternoon. Are you still happy to be involved in the handover?
Amanda: No
Nurse 1: Thanks Amanda, is there a particular reason why you don't want to be involved?
Amanda: (*Poor eye contact, shrugs shoulder*). Don't know
Nurse 1: Ok, I understand**.** Do you mind if myself and Nurse 2 handover in your presence though?
Amanda: OK.
Nurse 1: So, nurse 2, Amanda started off the day in the AMA not talking, she was given some medication and later reported feeling better. Her main concern is about her friend Caroline who she feels has been taking advantage of her.
Nurse 2: Amanda, I hope to catch up with you shortly after the handover and we can work through some of your concerns, is that OK?
Amanda: That is Ok.
Nurse 1: Well, thanks Amanda, I finish off my shift shortly, take care.

AM Nurse:	PM Nurse:

CASE SCENARIO 4 DETAILS	NHIC (with carer also present)
PARTICIPANTS:	Jonathan (Client), Nurse 1 (AM Nurse), Nurse 2 (PM Nurse), Claire (Jonathan's mum)
SETTING:	Handover occurring in Interview Room

BACKGROUND INFORMATION ABOUT THE CLIENT (AVAILABLE ON THE HANDOVER SHEET)

24 yo male, currently in a relationship and living with his mother in ministry of housing accommodation. Presented to ED on advice of GP requesting admission due to increased auditory and visual hallucinations over the past 6 weeks. Predisposing factors include long history of substance use, history of self-harm/suicide attempts, antisocial personality traits and childhood physical abuse. On admission: Pleasant and cooperative, anxious and mildly agitated, compliant with all nursing interventions, initially refused to sleep in his room as it is in the female corridor stating female co-patients might make allegations, but as he could not settle on the couch he eventually settled to bed after utilising 20mg of regular nocte olanzapine and 20mg Temazepam at 0230 and has been asleep since. c/o foot numbness needs r/v Bloods charted for tomorrow?

24 HOUR HANDOVER (AVAILABLE ON HANDOVER)

R/V by Consultant. CLAMS referral re: Rehab option. Pleasant and cooperative, anxious and mildly agitated, compliant with all nursing interventions, mood as low, some reactivity. NFTD. Suicidal thoughts at times. Nil plan or intent on the ward. Reported ongoing auditory hallucinations of a child laughing when he is trying to sleep. Bloods this morning. Utilised 5mg diazepam at 1130hrs.

NHIC WITH JONATHAN AND CLAIRE IN ATTENDANCE (SCRIPT)

Nurse 1: Good afternoon Jonathan, remember we discussed about your involvement in the handover earlier this morning. I would like to introduce (Nurse 2) who will be looking after you this afternoon. Are you still happy to be involved in the handover and also for your mum to sit in?
Jonathan: Yes that is fine.
(Claire (Jonathan's mother) *walks into the ward to visit Jonathan….)*
Nurse 1: I see Claire has just arrived on the ward, would you like her to be part of the handover as well?
Jonathan: Yeah that is fine.
Nurse 1: So Jonathan do you mind telling Nurse 2 and I how you have been going this morning?
Jonathan: I have been feeling a bit anxious, still having thoughts to harm myself but I would not do anything here. I still hear voices.
Nurse 1: Anything else?
Jonathan: No that's about it.
Nurse 1 & 2: Thanks Jonathan**.**
Nurse 1 turns to Nurse 2: Nurse 2, Jonathan was seen this morning by Dr Brad, no changes have been to his medications and has he mentioned has been feeling anxious and also having suicidal thoughts . He was given 5mg diazepam at 1130hrs……. (Jonathan cuts in…)
Jonathan: I think it might have been 10mg?
Nurse 1: (checks notes), yes you are right it was 10mg, thanks for clarifying that.
Nurse 1 (continues): A referral to CLAMS was suggested and Jonathan is happy for this to occur. I have not been able to complete the referral are you able to please complete?
Nurse 2: Not a problem we can do that together later on Jonathan.
Nurse 2: Jonathan, is there anything else you would like me to look into before we catch up later?
Jonathan: Oh, can I get some leave with my mum so we can go to the shops?
Nurse 1 & Nurse 2: That should be OK, you do have escorted leave off the wards.
Nurse 1: Claire is there anything you would like to add?
Claire: No, I think he is getting better, thank you for looking after him.
Nurse 1 & Nurse 2: You are welcome.
Nurse 1: Jonathan, I'll be finishing off soon, take care.
Nurse 2: Jonathan, I will see you once you return from leave with Claire, thanks.

AM Nurse:	PM Nurse:

CASE SCENARIO 5 DETAILS :	Multiple care needs/request & Arguments
PARTICIPANTS:	Trevor (Client), Nurse 1 (AM Nurse), Nurse 2 (PM Nurse)
SETTING:	Handover occurring in Interview Room

BACKGROUND INFORMATION ABOUT THE CLIENT (AVAILABLE ON THE HANDOVER SHEET)

50 year old single male lives with mum. Well known to our services. Last admission Feb 2015. Dx of SAD, managed by community team. Concerned about his mental status. Poor sleep, increased sexual themes, believing he is Jesus Christ. Hx trying to physically assault his mum when unwell.

24 HOUR HANDOVER (AVAILABLE ON HANDOVER)

Poor ADLs, unkempt, superficially co-operative. Distracted +++, Argumentative, difficult to interrupt, Labile, agitated at times. Mood as good. Believes he is 'Stephan' descended from heaven. Also identifies self as 'Jesus Christ the Messiah'. Auditory hallucinations of Stephen. Overly responding to A/H. Flight of ideas. States circumstances surrounding this admission were a mistake, just wanting to be discharged. Poor insight. Impaired judgement. Needs UDS. S.V Levels and other bloods this morning.

NHIC WITH TREVOR IN ATTENDANCE

Nurse 1: Good afternoon Trevor, remember we discussed about your involvement in the handover earlier this morning. I would like to introduce (Nurse 2) who will be looking after you this afternoon. Are you still happy to be involved in the handover?
Trevor: Yes, absolutely.
Nurse 1: So, Trevor can you just let us know how you have been feeling today?
Trevor: I am feeling fine, you guys know that there is nothing wrong with me and you keep holding me in this place. Can I have leave now from the ward?
Nurse 1: Thanks Trevor we'll discuss your leave later but remember what you were telling me in the morning about being Stephan and Jesus and that you were hearing voices of ……
(Trevor Interrupts)
Trevor: Can we just talk about my leave…., just to let you know I will not be taking that medication so you can tell the doctor to shove it ********.
Nurse 2: I understand Trevor and appreciate you are upset, how about I touch base with you later and we can discuss your leave and other things you may want to discuss.
(Trevor mutters under his breath)
Trevor: OK, make sure you don't piss off ……
Nurse 2: I will catch up with you after handover

AM Nurse:	PM Nurse:

Summary of Case Scenarios

Case Scenario 1 (No client involvement & breach of confidentiality) X	Case Scenario 2 (Multiple care needs/request & Arguments) X	Case Scenario 3 (Not willing to engage) X	Case Scenario 4 (Nursing Handover Involving Clients) ✓	Case Scenario 5 (Multiple care needs/request & Arguments)
• Client agrees to be involved in the process. • However, Nurse to Nurse handover taking place without client engagement/involvement (nurses talking to each other). • Include confidentiality and privacy breach (Shared bedroom, corridor, balcony area)	• Client well engaged in process. • Nurse to Nurse handover taking place with client involvement. • Client difficult to interrupt with multiple request and care needs. Client with thought disorder. • Client disagrees with information and this escalates into an argument between client and nurses.	• Client not willing to engage in process. • If client agrees with the nurse to nurse handover occurring without their input however in their presence, then proceed. • If client does not want this to occur in their presence, then nurse to nurse to occur at different location.	• Client well engaged in process • Nurse to Nurse handover occurring with client involvement. • Ask client for consent to involve carers. • Using appropriate language • Carer arrives on ward at time of handover	• Client well engaged in process. • Nurse to Nurse handover taking place with client involvement. • Client difficult to interrupt with multiple request and care needs. Client with thought disorder. • Client disagrees with information but nurses are able to deescalate without an argument occurring.
Case Description (see running sheet)	**Case Description(see running sheet)**	**Case Description(see running sheet)**	**Case Description(see running sheet)**	**Case Description(see running sheet)**
Key Elements of an effective client involved handover	Things to avoid in a client involved handover system	Preparatory work before handover	Environmental concerns	Role of the ANUM
• Client voice is heard during the process • Client is able to corroborate or dispute information • Miscommunication is avoided. • Acknowledge client needs and set time frames and expectations for the next shift is set • Accurate information is passed across • Client is treated as a partner in the care process • If Client disagrees with information then nurse prompt the client about the previous discussions. If client continues to disagree then avoid arguments that would further escalate the client. • Quick Identification of needs • Timeframe for the next engagement discussed with the client to meet the needs.	• Handover used as a mere meet and greet time. • Nursing staff talking about the client as opposed to with the client • The use of psychiatric jargons	• Outgoing Am nurse should inform the client about the nature of upcoming handover, i.e. time, what would occur. • Seek consent of the client before the handover • Anticipate carer/significant others presence, ask client if they want them involved.	• Avoid crowded areas • Maintain privacy and confidentiality • Adopt basic principles of therapeutic communications and engagement.	• ANUM to be mindful of allocation and try where possible to allocate groups of client to nurses (being mindful of relevant CPGs i.e. gender, etc.)
Things to be done post-handover				
Documentation of the process: if it occurs what were the main concerns of the client. If process did not occur state reason in nursing progress notes i.e. client was asleep, off the ward, in a group.				