ABSTRACT
The World Health Organization (WHO) has recognized that errors in communication are one of the leading causes of adverse patient outcomes. Consequently, the WHO developed the High 5s Project to review, among other variables, handover of patients between shifts, professionals, and organizations. Seven countries were involved in the initial project. Australia responded by using the ISOBAR (Identify, Situation, Observations, Background, Agreed plan, and Read-back) tool as a template. However, none of the countries involved considered the social and emotional effects of handover on the staff or patients, although research has demonstrated that attitudes and values can be handed over from one nurse to another during this process. This article shows how the nurse who hands over care from one shift to the next can transfer stigma and labeling and offers suggestions for nurse educators and clinicians to apply national standards and core values to clinical practice and education.

Stereotyping Stigma: Undergraduate Health Students’ Perceptions at Handover
Kerrie Esme Doyle, RN; and Mary Cruickshank, PhD, RN

Handing over care of patients from one nurse to another has undoubtedly been the practice since the first nurses cared for an ill person. The information shared generally consists of the patients’ current condition, recent changes in condition, ongoing treatment, and possible changes or complications that might occur (World Health Organization [WHO], 2007). However, the attention on handover linked to patient outcomes has intensified over the past decade. Getting the practice of handover correct is quintessential to patient safety. In Zinn’s (1995) landmark report, 11% of the 30,000 preventable adverse patient events that led to permanent disability in Australia involved communication issues. From 1995 to 2004, nearly 70% of all Australian sentinel events indicated communication as the root cause (Hughes, 2007), and health professionals themselves perceived that clinical problems can be attributed to poor clinical handover (McCann, McHardy, & Child, 2007), such as incomplete handovers, illegible handwriting, and unclear instructions (WHO, 2008, p. 18). In a hierarchical system such as health care, junior clinicians may not feel confident to speak out about concerns they may have (WHO, 2008, p. 19); when errors of omission or corruption affect the handover of patient information, future decisions may be based on inaccurate information and medical and nursing errors may occur (Bomba & Prakash, 2005).

This mode of error is not peculiar to Australia, and the WHO has recognized the global threat to patient safety due to communication issues. In 2006, the WHO, in concert with the World Alliance for Patient Safety, launched the High 5s Project aimed at improving five patient safety problems over 5 years (WHO, 2007). The participating countries in this 2006 project were Australia, Canada, France, Germany, the Netherlands, the United Kingdom of Great Britain and Northern Ireland, and the United States, with France, Saudi Arabia, and Singapore joining subsequently. The aim of this project was to “facilitate implementation and evaluation of standardized patient safety solutions within a global learning community to achieve measurable, significant and sustainable reductions in challenging patient safety problems” (WHO, 2007, p. 3).

The operationalizing of the recommendations from the High 5s Project included the creation of standard operating protocols. Five standard operating protocols have been developed to
support the project. These standard operating protocols concentrated on assuring medication accuracy at transitions in care, managing concentrated injectable medicines, performing the correct procedure at the correct body site, addressing health care-associated infection, and avoiding communication failures during patient handovers. Each country in the project was responsible for managing their national responses to these protocols.

Acknowledging the risks to patients, the standard operating protocols identified communication during patient care handover as one of the five target areas. In response to the outcomes and reports from this project, signatory countries then proceeded to operationalize these strategies, and in 2007 the WHO produced the Nine Safety Solutions report, ostensibly “to translate what is currently known in these areas to action, guiding the redesign of care processes to prevent patient harm” (WHO, 2007, p. 3).

One of the safety solutions focused on communication during patient handovers (Chaboyer & Blake, 2008).

Given that patient safety and clinical handover are often at the root of adverse patient outcomes, the WHO (2007) mandated its signatory countries to review their handover techniques, including shift-to-shift handover among clinical care givers. In response, the Australian Commission on Safety and Quality in Health Care, the leading federal government technical agency involved in the area of clinical handover improvement (Turner, Wong, & Yee, 2009), delegated the state health departments to assess, implement, and review strategies to decrease the number of events under this outcome. This agency officially commenced as an independent, statutory authority on July 1, 2011, under the National Health and Hospitals Network Act (2011). The Australian Commission on Safety and Quality in Health Care (2010) created the OSSIE guide to clinical handover (Organizational leadership, Simple solution development, Stakeholder engagement, Implementation, and Evaluation and maintenance) to steer the creation of operational handover protocols, thus allowing each state and organization to design a tool that best fits their particular requirements.

In New South Wales, Australia, for example, the Department of Health conducted a public inquiry into the provision and governance of acute care services in New South Wales public hospitals. The resulting Garling Report, produced in 2008, recommended structured clinical handover and improved culture within health services (Bradfield, 2010).

Consequently, Australian public hospitals developed handover tools or templates for staff to follow. Western Australia, for example, introduced the ISOBAR (Idenfity, Situation, Observations, Background, Agreed plan, and Read-back) tool for effective handover of patients from remote and rural health clinics to the Royal Flying Doctor Service for transfer to major hospitals (Porteous, Stewart-Wynne, Connolly, & Crommelin, 2009).

This has helped staff in stressful, often life-threatening situations to be better able to hand over patients with clarity (Yee, Wong, & Turner, 2009). The New South Wales Department of Health (2009) has also developed a learning package and a committee to review handover policies and practices in each of its area health services. Both state programs mandate the process and define the information required within that process. The New South Wales Department of Health (2009) modified the ISOBAR and uses the ISBAR (Information, Situation, Background, Assessment, and Recommendation) handover tool. A copy of the tool is taped to a wall next to the telephones in clinical areas so that clinicians handing over patients to other care units will have access to and comply with this standardized model of communication.

The United Kingdom had a similar response to Australia. The Joint Commission (2008) reported that breakdowns in communication are the root cause of 65% of all sentinel events in the United Kingdom. However, the commission astutely realized that patient care transfers from nurse to nurse, nurse to doctor, doctor to doctor, or among other team members differ in all instances in content and context. Consequently, in 2008, the Joint Commission put into effect a National Patient Safety Goal mandating that hospitals improve the effectiveness of handover communication and suggested examples of care transfer templates for communication between nurses, doctors, and institutions. The mandate meant that health organizations were required to implement a standardized approach to communication among caregivers, which included the opportunity to ask questions and have them answered. This was based on evidence from the airline industry, where hierarchy was flattened to increase effective communication (Mascioli, Laskowski-Jones, Urban, & Moran, 2009).

Using evidence from practitioner surveys, the Joint Commission developed the DATAS acronym for patient report (Demographic and diet information; Assessments and allergies [including a medication review of newly prescribed medications]; Tests and test results [outstanding and completed], including all point-of-care testing and current cardiac rate and rhythm if on telemetry; Alerts, such as patient isolation and do-not-resuscitate orders, and any additional concerns; and Status of the patient within this plan of care and the discharge process, including anticipated date of discharge). Nurse-to-doctor and doctor-to-doctor handovers in the United Kingdom use the SBAR acronym (Situation, Background, Assessment, and Recommendation) (Mascioli, et al., 2009), similar to the ISOBAR or ISBAR tools used in Australia.

HANDING OVER MORE THAN CLINICAL INFORMATION

Nursing practice is evidenced based, so it is appropriate that organizations and professions mandate handover processes; however, handing over of patients is more than an exchange of clinical information. Handing over also has social functions, such as increasing teamwork in units (Mackintosh, Berridge, & Freeth, 2009) and providing emotional support for nurses (Hopkinson, 2002), yet none of the responses to the WHO or the national mandates consider the humanistic aspects of handover (Bouchex & Corin, 2008; Carroll, Iedema, & Kerridge, 2008; Messam & Pettifer, 2009; Miller et al., 2009).

Notably, for example, the person handing over is able to influence the subsequent shift nurse in a number of ways (McCloughen, O’Brien, Gillies, & McSherry, 2010). This is where the values of an organization or unit are enculturated to the oncoming shift (Philpin, 2006). During handover, nurses at times refer to patients in stereotypical ways (e.g., “he’s anxious” or “she’s a sweetie”), and the receiving nurses accept and promulgate these labels. These handover behaviors reflect the ward culture and level of the nurses’ anxiety (Evans, Pereira, &
TABLE 1
Clinical Narrative: Tegan

<table>
<thead>
<tr>
<th>Positive comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tegan has had a good night. I think she feels a little sheepish about last night. I have spent time with her, and she is really trying hard to get her head together. We have found a good program for her, and she will go to the meetings—I think we might have found a good match for her this time.</td>
</tr>
<tr>
<td>Negative comments:</td>
</tr>
<tr>
<td>Well, Tegan is back again after another night of seeing how far she can push the boundaries. The social worker has found her a program, but I reckon she won't even bother to turn up to those either. Good luck with her today—just try and get her out of the ED—I am sure there are plenty of others waiting for the bed who are really sick!</td>
</tr>
<tr>
<td>Questions for students:</td>
</tr>
<tr>
<td>What members of the multidisciplinary team might be involved in the care of this patient?</td>
</tr>
<tr>
<td>What emotions does this patient engender in you and why?</td>
</tr>
<tr>
<td>What would you need to do for this patient over the next 8 hours (e.g., vital signs, behavioral observations)?</td>
</tr>
</tbody>
</table>

Parker, 2008) and, in turn, the social context of handover influence nurses’ behaviors (Miller et al., 2009). Complex group processes, such as peer pressure, are used to gain conformity to a peer group’s diagnosis (Pickering, Hurley, & Marsh, 2009).

The handover ritual itself is a function of group formation, and importantly, it gives “expression in a disguised form to the way the patient moves the nurse to love and hate” the patient (Evans et al., 2008, p. 45). In complex handover situations, where the complexity of handover increases with the introduction of multidisciplinary team members (such as in emergency departments or mental health units), the pressure for timely clinical decisions and the organizational, cultural, behavioral, and environmental factors associated with team performance can undermine the stability of team functioning (Botti et al., 2009), causing stigmatizing handovers to be left unchallenged.

HANDING OVER PATIENTS WITH MENTAL HEALTH DIAGNOSES

Contemporary mental health nursing is defined by its emphasis on the holistic balance of psychosocial and biomedical caregiving and care planning (Yonge, 2008); however, 52% of patients admitted to a mental health institution with a diagnosis of psychosis experience posttraumatic stress disorder as a consequence of their admission (Watkins, 2009, p. 11). The organization can bear only some of the responsibility for this statistic—caregivers must also look at their contribution to dehumanizing mental health patients. This process starts at admission (Doyle, 2011) and is permissioned by staff at every shift’s end, where the content and context of the nursing handover is not always fully integrated with the core values of mental health nursing (Cloughen, O’Brien, Gillies, & McSherry, 2008).

Using negative terms, for example, to describe and stereotype patients with challenging behaviors is common in nursing handovers (Evans et al., 2008), and nurses working with long-term mental health patients often have stigmatizing attitudes (Horsfall, Cleary, & Hunt, 2010). When a rare dissenting view is expressed, the difference is minimized by the moving on of the handover to avoid conflict between the nurses. Similarly, when a judgment is made about a patient by the nurse handing over, it is not usually challenged by other nurses (Parker, Gardner, & Wiltshire, 2004). Clinicians might not remember the details of handover (Pickering et al., 2009), but they do remember the emotions engendered in them by the handover ritual itself (Yonge, 2008).

Therefore, the transfer of stigmatization in nursing practice is an area that needs research. Educators of undergraduate nursing students in Australian learning institutions should responsibility to ensure graduates will meet the Australian Nurs-
Mental health is part of the core national curriculum for undergraduate nursing degrees in Australia. As part of the Bachelor of Nursing degree, we offer a compulsory 3-credit generalist mental health course. Admission to this course is open to students from other disciplines who want to gain work-integrated learning in mental health care. Approximately 190 students are generally enrolled in this unit. The students self-select their tutorial groups for the semester and are required to attend for 2 hours each week. Each tutorial group typically has 20 students.

For this study, two tutorial groups of 20 undergraduate health students \((N = 40)\) were invited to participate. Seventy-five percent of the students were in the second year of the Bachelor of Nursing degree \((n = 30)\); 15% were student midwives \((n = 6)\); and the remaining 10% were enrolled in physiotherapy, psychology, dietetics, or sports sciences \((n = 4)\). The same educator led both tutorial groups.

### Instrument and Tools

Two versions of two patient case studies were presented to the student groups. The first case study described Tegan, a fictitious patient with a personality disorder. In the first version, the handover nurse described Tegan in negative terms (e.g., “manipulative, noncompliant”). In the second version, the handover nurse described Tegan in positive terms (e.g., “trying hard”). In each case study, the same nurse presented handover of the same behaviors (e.g., Tegan had unprotected sex with a stranger in a parked car) (Table 1).

The second case study described Julie, a fictitious patient with an eating disorder. Again, in the first version, the handover nurse described Julie as manipulative and noncompliant. The second version described Julie in sympathetic or positive terms (e.g., “trying hard” or “poor thing”). In each version of the case study, the handover nurse described the same behaviors (e.g., Julie refuses to go to group therapy) (Table 2).

The first student group was given the positive Tegan and the negative Julie case study, and the second student group was given the negative Tegan and the positive Julie case study.

A positive and negative case study was read to each group by the same educator in all four readings. After each case study, students were asked to write on an answer sheet three emotional responses that the patient engendered in them.

### Table 2

**Clinical Narrative: Julie**

| Julie is a 16-year-old, highly intelligent, attractive girl from a family of high achievers. Her father, Matt, is a successful businessman, and her mother, Olive, is a well known public advocate for cancer research. Her parents have been divorced for 11 years. Julie is their only child and is currently in year 11 at a private girl’s school in Sydney. Matt lives overseas. Julie is expected to do well academically and go on to study medicine at university. As far as we know, her childhood development was normal and her upbringing privileged. In the past 6 months, Julie has lost a lot of weight, looks physically ill, and complains of lethargy. Julie eats little food and irregularly. Her periods have stopped. Her school work has suffered, and she has been sick on numerous occasions during the term. She now weighs 83.6 lbs and is 4 ft 9 in. tall. In desperation, Olive took Julie to her own general practitioner (GP). Julie was not very cooperative during the GP appointment. The GP made a provisional diagnosis of anorexia nervosa. The GP has further recommended specialist psychiatric treatment in an adolescent unit that specializes in the treatment of this disorder. Julie refuses to be admitted to the hospital but agrees to participate in the specialist outpatient program where you work. This program consists of nursing staff, psychologists, and nutritionists, as well as medical staff. You are about to start your duty shift and are taking handover from the nurse in charge of the previous shift. Positive comments: Julie is a shy person who is trying hard to overcome her eating problem. We are going to be trialing a new treatment program for her, so she will need encouragement and support from the next shift for her to participate. Say positive things to her, please—she is a really nice young woman, and we need to help her in this part of her journey. Negative comments: This is the fifth time we have had Julie, and nothing seems to work for her. I don’t think she really wants to get better anyway. They are going to try another new program for her—so I guess we’ll have her in the program for a while, taking up a space that someone else could have used. Questions for students: What members of the multidisciplinary team might be involved in the care of this patient? What emotions does this patient engender in you and why? What would you need to do for this patient over the next 8 hours (e.g., vital signs, behavioral observations)? |
sheets were then handed to the tutor. Students were also asked further clinical questions to mask the intent of the exercise and to deemphasize any perceived need for students to look good by writing only what they perceived to be positive emotional responses.

RESULTS

The responses for the positive and negative versions of the case studies were counted. If a student stated he or she would not feel like devoting much time to this patient, that response was counted under “time wasting.” The responses were categorized as Anger, Time Wasting, Self-Destructive, Uncoachable, Empathy, Sympathy, Challenging, and Treat the Same. One response, Treat the Same, scored high in both scenarios due to a cohort of midwives answering that they would ignore the stigmatizing comments of the handover nurses and would treat both patients in the same manner. The responses for both scenarios included Sympathy and Challenging, with all students feeling both patients were Self-Destructive (Figure 1).

The responses for the positive case studies were mostly positive and were negative for the negative case studies. In the negative case studies, 78% of student responses stated the patient would make them feel angry and that the patient was self-destructive, uncoachable, and was wasting their time as a nurse, whereas only 20% of the responses stated the patient engaged emotions of empathy or sympathy and that the patient was challenging. The six student midwives stated unequivocally that they would treat the patient the same as any other patient.

In the positive case studies, no responses included anger or time wasting, but all student responses agreed the patient was self-destructive and challenging. However, 95% of students listening to the positive handovers felt sympathy toward the patient and 30% further felt empathy.

Further collapsing the responses over positive and negative case studies demonstrated the transfer of negativity and positivity from the senior (handing over) nurse to the novice nurse (Figure 2). Although there was some crossover of emotional responses between positive and negative case studies, there was a significant difference between the two case study groups ($F = 0.53$). This suggests a distinct difference between the responses in students hearing stigmatizing handovers (i.e., a judgmental view), either positive or negative, as easily conveyed at handover.

DISCUSSION AND RECOMMENDATIONS

Magnet hospitals (those that have easy recruitment and high retention of nursing staff) have effective handover processes (Stordeur, D’Hoore, & Next-Study Group, 2007) suggesting that handover is an important component of nurse job satisfaction. However, handover, as a discrete skill, is either not routinely taught to undergraduate nurses (Scovell, 2010) or is not taught effectively (Nestel, Kneebone, & Barnet, 2005), although the WHO (2007) mandated that handover of patients from shift to shift and from care organization to organization be conducted in an effective, evidenced-based manner.

Effective handover is a difficult task to achieve within the context of high patient turnover, a lack of overlap time between shifts, and time constraints due to checking of equipment and other activities that detract from patient handover (O’Connell & Penney, 2001). Also, the push for more savings of the health dollar might add pressure to dismiss this activity of daily nursing; however, nurse educators need to consider the social and emotional effects of handover to the patient and the novice nurse and prepare new graduates to reject biased attitudes exhibited by other health professionals.

Our study suggests that the attitude of the nurse handing over, seen as senior or as having expert knowledge of the patient being handed over, was accepted with minimal questioning. Notably, midwives did not seem to be affected by the stigmatization process of handover. Discussions with senior midwife academics suggest that the model of midwifery is an empowering one, and student midwives are taught early to interrogate their assumptions as independent clinicians.

One in five Australians will experience a mental illness in their lifetime (Wynaden, 2010), and the majority of patients re-
quiring intervention will be cared for in the general health care system (Happell, 2008). This can be stressful for nonmental health nurses, especially because currently there is no appropriate mental health triage in generalist emergency department presentations (Broadbent, Creaton, Moxham, & Dwyer, 2010; Doyle, 2011). However, specialist mental health nurses, have recognized the threat of stigmatizing patients and have adopted the recovery model of mental health to promote hope in clients. This model therefore helps reduce the stigma associated with mental health disease (Trossman, 2011), which suggests a professional recognition that stigmatization of mental health patients by clinicians leads to poor patient outcomes.

Not questioning assumptions at handover threatens novice nurses’ ongoing development. Empathy, for example, is critical in the social system because each nurse’s ongoing development determines the capacity to be appropriate, effective, and influential while seeing the personal, interpersonal, and professional self in relation to the task at hand. Quality outcomes in nursing social systems depend on the empathic capacities of individual nurses (Alligood, 2002).

Handover is a splinter skill of the communication skills set required in health care delivery; therefore, educators need to teach handing over in a manner so that the observer, incoming shift nurse, or novice practitioner can identify the core values of the handing off nurse and how to safely contest the stereotyping that detracts from the humanity of that patient.

The challenge, then, for health educators is to embed the core values of the national standards of care, including ethical practice, not only in the curricula but also in the students. It is imperative on all levels for clinical and academic nurses to understand the importance of handover and to include this skill in the curriculum for all specialties of nursing.

REFERENCES


