Caregivers' Bias and Communication at Patient "Hand-Off": The Benefits of the Bring it Bedside Program

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ABSTRACT

This article describes the creation of the "Bring it Bedside" program at Children's of Minnesota. The program standardizes the hand-off of patients' information within patients' rooms, that is, at the bedside, allowing the greater involvement of patients and family members in sharing information about the plan of care. Family members report the program supports their involvement in their child's care and strengthens their trust for their careproviders.

BACKGROUND AND INTRODUCTION

Bias

The word *bias* has been defined as a preconception, partiality, and prejudice about something or someone.[1] A bias may be favorable or unfavorable. It is further described as a tendency to believe that some ideas and people are better than other ideas or people.[2] The belief that one's own ideas are better than another's may result in treating others in a negatively biased way.

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In healthcare there is concern about what is called *caregivers' bias,* that has the potential to adversely affect the patient-caregiver relationship (trust) and the delivery of care itself. Bias can be both explicit and implicit. *Explicit bias* is when an individual is consciously aware that she or he holds a belief about a person. *Implicit bias* is a belief about a person that is unconscious. Both types of bias may play a role in how a caregiver treats a patient, impact the building of trust, and lead to problems in the delivery of care.[3] Bias can occur in the healthcare setting due to gender, race, religion, social status, education, and age.

Bias can also occur when there is a gap in collaboration.[4] In pediatric healthcare, such a gap can occur when a family makes a decision about a treatment for their child that a nurse does not understand or think is appropriate. A nurse can project a conclusion that has a root in bias about the family and their treatment decision. Such conclusions can lead to conflict if information about the patient that is shared is incomplete or is communicated with bias by another nurse.[5]

The ethical framework for nursing practice includes respect for persons that is nonjudgmental and fair.[6] Nurses must strive to promote the autonomy of patients—the right of patients to their own views, and to take actions on their views. In pediatrics, this

may become difficult because parents are presumed to be the best decision makers for their child.[7] Lastly, nurses are expected to keep promises, practice fidelity, tell the truth, practice veracity, and treat people evenhandedly—with justice. These principles are the ethical framework for nursing and are fundamental elements for the delivery of care. They can affect caregivers' bias. Patients and families develop trust for their nurse, if he or she demonstrates respect for the patient and family. Providing competent care, allowing patients and families to be involved in care and make decisions, telling the truth, keeping agreements, being consistent, practicing compassionate listening, and maintaining an open dialogue are the foundations on which trust is built.[8]

Patient "Hand-Off"

In an article entitled "Ethics of Shift Report," Cynda Rushton points out that patient "hand-off" has the potential to result in the transmission of incorrect information regarding patients and family members.[9] *Patient hand-off* is the process of passing the responsibility for care of a patient from one healthcare professional to another. In this article, it refers to two nurses who transfer care for a patient between shifts. In her article, Rushton describes the ethical framework of the patient hand-off (the shift report). Rushton points out that the hand-off process can result in a "vehicle for gossip, disrespectful communication and blame, each with the potential for undermining relationships and trust."

The potential for nurses to discuss and repeat unverified facts, assumptions, and opinions can become a source of bias in delivering care to patients and their family members. Such biasing communications may be an expression of nurses' moral distress and burnout, which have been linked to the care of patients who are critically ill, have decreased decision-making capacity, and who are receiving care that, in the nurses' perception, is nonbeneficial, or when the burden of care seems to outweigh its benefit.[10] Similarly, the use of labels to describe patients at the hand-off (for example: "a real pain," "belligerent," "a sweetheart," *et cetera*) may bias a receiving nurse's perceptions of a patient and family members.

Bias, then, should be understood and discussed by nurses to create an ethical framework for the delivery of care, and to guide communications during patient hand-off. This article will discuss the ethical issues of the patient hand-off. The article will also describe how two interventions—standardization of the hand-off process and completing the hand-off at the bedside—were implemented through the "Bring it Bedside" project at Children's Minnesota (Children's) to reduce bias and ultimately lead to improved quality of care.

CHILDREN'S "BRING IT BEDSIDE" PROJECT

Background

In 2016, the nursing strategic plan at Children's included an initiative to improve the process of patient hand-off, using a standardized format and bringing hand-off to the patient's bedside. This practice change project was implemented through a shared governance model that includes the input of more than 200 clinical nurses. The project was titled "Bring it Bedside." The time and resources required were supported by nursing leadership and advanced practice nurses.

Bring it Bedside began with a survey of clinical nurses to assess attitudes and concerns about the hand-off process then in use. It was also used to determine if nurses felt a change was needed. The survey went out to all inpatient nurses on all campuses including St. Paul, Minneapolis, Minnetonka, and the Special Care Nursery at Mercy. The survey consisted of 11 questions, and respondents had an option to provide additional comments. The survey results confirmed that a new process for patient hand-off was essential. During the preliminary implementation process, concerns were identified by clinical nurses that the process then in use for patient hand-off carried a risk for creating bias.

This led to more work to identify the ethical issues involved in patient hand-off. An article by Rushton in 2010 listed the following six strategies for ethically grounded patient hand-off:[11]

1. Monitor language and tone: be mindful about the words used to exchange information, and work with your colleagues to identify wording that is unclear, hurtful, judgmental, or critical.
2. Challenge assumptions: question information that is not objectively supported.
3. Be alert to the presence of gossip: this may be an indication that there is a need to address an aspect of care or the external environment. Consider consultation with another nurse, manager, or educator if this is of concern for a particular patient.
4. Develop professional norms: hold each other accountable to the process and respect of the process, make it a part of the unit culture to support the respect of persons during hand-off.
5. Use a standard framework to address essential patient information and reduce the sharing of non-essential or inappropriate information to

improve efficiency and maintain respect for persons.
6. Decide on a "need to know" policy: determine what information needs to be shared and with whom.[12]

Through the use of Rushton's article, the Bring it Bedside project assisted in decreasing bias and ethically grounding hand-off through two major components: (1) standardization of the hand-off process and (2) completing hand-off in the patients' room—at the bedside. Standardization of the hand-off process was supported by Rushton's strategies 4 through 6, while hand-off within patients' rooms supports strategies 1 through 3.

METHODS

Once the survey data were shared and a review of the literature was completed, work began with individual units to develop a new process for patient hand-off. Nurse representatives from every unit are part of the shared governance structure that is in place at Children's. These clinical nurses are joined by nursing managers, supervisors, clinical educators, and advanced practice nurses (clinical nurse specialists and clinical practice specialists) to form unit councils. These unit councils developed standardized forms and education plans for their individual specialty areas.

Standardization

The standardization of patient hand-off is broadly supported by several agencies and safety initiatives including the Institute of Medicine, the Joint Commission, the World Health Organization, the Accreditation Council for Graduate Medical Education, and, most recently, the American Academy of Pediatrics.[13] Research indicates that standardization is a proven way to reduce adverse events related to breakdowns in communication between healthcare providers.[14] With implementation of such standardization, authors have reported dramatic improvements in the continuity of patient care and the ability to provide accurate information to an oncoming caregiver.[15] Common sources of bias for nurses include an error in understanding or not following a standard procedure.[16] Standardizing the format for hand-off led to unit-based discussions on the essential content social information on the family and patient. The standardized nursing hand-off form design required that nurses gain consensus on "need to know" social information that was essential for the nurse who was assuming patient care responsibilities.

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The standard format selected and implemented at Children's was the Situation, Background, Assessment, Recommendation (SBAR) form. This tool provides a template to guide the hand-off of essential, objective patient information that is specialty specific. This standardized form sets the expectation of what one nurse needs from the previous nurse. Each unit council developed SBAR content using essential data that were identified by clinical nurses in consultation with nurse educators, the nursing literature, and clinical experts (advanced practice nurses). The use of a standard framework works to reduce the sharing of extraneous, inappropriate, or inaccurate information that can lead to bias.[17]

Once the content of the form was determined, unit councils and clinical nurses met to operationalize the information to reduce confusion and gain consensus on what each element of the form meant. For example, in the Assessment section, nurses agreed that information communicated from a systems approach would be for exceptions or abnormal findings only, and not include a listing of findings within normal limits. Another example included discussion about what social information was essential and should be included in hand-off. Although this discussion continues, it has been concluded that hand-off should include the names of the primary caregivers, their visiting patterns, their expressed unique requests/goals, and any additional pertinent information such as the need for interpreters or identified learning needs. The elements of

social hand-off have the greatest potential to contribute to bias. Therefore, there is ongoing evaluation and discussion on how to balance the benefits and burdens of sharing social information during hand-off, with the ultimate goal of sharing only information that is relevant to the care of the patient.[18]

Bring it Bedside

The second component of the Bring it Bedside practice change was handing-off patient information within a patient's room—or at the bedside. This change supported Children's care delivery system of patient- and family-centered care through patients' and families' involvement in the sharing of information about the plan of care.[19] The literature reports that patients and families involved in a nursing hand-off have a better understanding of the plan of care and improved satisfaction with communication during their hospital stay.[20] Families also reported that a bedside hand-off process supported their involvement in their child's care and strengthened their partnership (trust) with their careproviders.[21] Since bias often can occur when a patient and family are categorized, a face-to-face bedside discussion improves the accuracy of the information received and allows questions from families, should the information not be accurate. This strategy of bringing hand-offs to the bedside has been reported to reduce implicit bias through a nurse's ability to ask questions and better understand the patient and family's point of view and improve everyone's understanding of the plan of care.[22] Involving the patient and family in the hand-off is a means of diminishing bias and building trust between the healthcare team, family, and patient.[23]

As bedside reporting requires nurses to concentrate on their communication so that they accurately relay only pertinent objective patient information,[24] deliberate practice and simulation are being added to education for both newly hired and currently employed nurses. Both simulation and deliberate practice allow nurses to identify how to best communicate at the bedside, with each other as well as with patients and families.

IMPLEMENTATION OF RESULTS

After the first quarter of organizational implementation, the Bring it Bedside project has not only seen an improvement in the quality of patient care, but also in patient and family satisfaction. Data are currently being gathered through patient and family focus groups, as well as patient satisfaction surveys related to nursing communication, and incident reports in which patient hand-off was a contributing factor. Bedside reporting will be evaluated over time by nurses, patients, and families to continue to support and improve this practice change.

CASE STUDIES

The following two case studies are patient hand-offs that did not follow the Bring it Bedside model. Either the component of standardization or patient and family involvement at the bedside were missing and led to caregiver bias.

Case Study 1

A 21-day-old boy was admitted with severe hypernatremia, dehydration, and weight loss by air transport. The parents were en route from more than 100 miles away, and little medical history arrived with the transport team upon the patient's arrival. Social information confirmed included the patient's name, date of birth, parents' names and address, along with laboratory information from the emergency department where the baby had initially been presented for evaluation. Test results in the intensive care unit documented sodium of 172, abnormal renal function, and brain imaging revealed some hemorrhaging in the ventricles. The plan of care included several consults with the Social Service Department and a rehydration plan allowing for a slow lowering of the sodium, and brain monitoring with a 24-hour electroencephalogram (EEG).

Several hand-offs occurred between nurses before the parents arrived. These hand-offs included a review of the medical plan, labs, medications, EEG information, as well as fluid and verification of the intravenous (IV) site. The hand-off also included information about the parents, their ages, where they lived, that this was a first baby, and that they were en route. The hand-off included additional discussion that speculated about why the parents had not sought medical help sooner. Nurses expressed concerns about the parents' judgment because they had allowed the child to become so ill. During team rounds, there were extensive discussions about the need to contact Child Protective Services and presumed neglect by the parents.

On arrival, the parents were evaluated by the Social Service Department and interviewed by the medical team. The parents gave detailed information about their baby's birth and visits to the pediatrician, as well as three visits to urgent care and eventually to the emergency department in their small rural hometown. Medical records were eventually

obtained to support this history and included instructions to change formula and take their son home. The parents were young and had limited financial and social support. The information shared during hand-off prior to their arrival had been inaccurate and unverified. Hand-offs had included irrelevant information sharing and bias about these parents. This bias took many days to "undo" and longer to rebuild trust between the parents and caregivers.

Analysis. While the standardized Bring it Bedside project would not necessarily have prevented this family from being viewed with bias, the discussion about the need for verified information to be used within hand-off will continue to support the process of using information that is standardized, to reduce assumptions. Any discussion of socially pertinent information must be verified, and, when done at the bedside, allows for family interaction and the confirmation of information. There is the potential to improve the trust relationship among nurses, families, and patients when the hand-off process is focused on objective, essential information. Hand-off at the bedside enables families to better trust nurses when they hear the review of their child's care and plan for the day.

Case Study 2

E.M. was a 10-year-old girl with a complex medical history recently complicated by an inability to take in adequate fluids and nutrients orally. She was admitted through the Children's Emergency Department, with a chief complaint of failure to use a newly placed gastrostomy tube (GT). Her mother was an adult obstetric nurse and her father was a family practice physician. After an initial history was taken from the parents, a new nurse came to assume care and the hand-off was completed outside the room. The hand-off included the nurse's physical findings and an ordered imaging study to determine tube placement. Once the imaging was done, it was determined that the tube required replacement, and the surgeon was notified. The plan was to discharge the patient once she had recovered from the new tube placement. The new, skin-level tube was placed successfully, and the child was transferred to the post-anesthesia care unit (PACU) for recovery and prepared for discharge home. A book for parents on the care of the new GT was given to the parents, and they were asked to sign a form indicating that they had understood the home-care instructions. The father was beginning to sign the paperwork when the mother interrupted, teary and visibly apprehensive, and said, "We do not know how to use this tube and weren't even sure how to use the last one." "This tube misplacement might not have happened if we had more teaching and time to learn the care before our last discharge." The PACU nurse then arranged to delay the discharge and contacted a coworker who could assume the care of the patient and complete the teaching. The surgeon was contacted about the potential need to have the child stay overnight to complete the instruction for the parents.

Analysis. In this case, the bias was that medical professionals need less instruction about tubes than other parents. The hand-off without the parents present did not allow for questions to be asked. What parents want and need cannot be assumed based on profession, age, education, or social status. Including families in the hand-off process presents an opportunity for the parents to hear the plan of care and ask questions. If the parents in this case study had heard the plan to discharge immediately after recovery in the PACU, their concerns and needs could have been addressed earlier.

SUMMARY

Children's utilized Rushton's article, including the six strategies to decrease bias through the Bring it Bedside project. The two major components were standardization and the completion of patient hand-offs within the patient's room. Standardizing nursing hand-offs promotes structured discussion of only essential and confirmed information about patients and families. It improves the quality, safety, and continuity of patient care. Bringing patient hand-off to the bedside decreases the risk of caregivers' bias by discouraging unsupported assumptions and false conclusions from being communicated to the oncoming nurse and by allowing the family to correct any false information. The Bring it Bedside project enhances the principles of truth-telling, justice, promise keeping, and respect for persons. The ongoing presence of patients and families during the hand-off helps to prevent the creation of negative bias.

PRIVACY

Details of the cases have been altered to protect the identities of patients and family members.

NOTES

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4. C. Rushton, "Ethics of Nursing Shift Report," *AACN Advanced Critical Care* 21, no. 4 (2010): 380-4.

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8. M.L. Reina, D.S. Reina, and C.H. Rushton, "Trust: The Foundation for Team Collaboration and Healthy Work Environments," *AACN Advanced Critical Care* 18, no. 2 (2007): 103-8.

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10. S. Gregory et al., "Bedside Shift Reports—What Does the Evidence Say?" *Journal of Nursing Administration* 44, no. 10 (2014): 514-45.

11. Rushton, "Ethics of Nursing Shift Report," see note 4 above.

12. Blair, Steiner, and Havranik, "Unconscious (Implicit) bias and Health Disparities," see note 1 above.

13. Gregory et al., "Bedside Shift Reports," see note 10 above; C. Pavlish et al., "An Evidence Based Model for Leaders Addressing Moral Distress," *Journal of Nursing Administration* 46, no. 6 (June 2016): 313-20; P. Cornell, M.T. Gervis, L. Yates, and J.M. Vardaman, "Impact of SBAR on Nurse Shift Reports and Staff Rounding," *Medsurg* 23, no. 5 (2014): 334-42; V. Arora and J. Johnson, "A Model for Building a Standardized Hand-off Protocol," *Journal on Quality and Patient Safety* 32, no. 11 (2006): 640-55.

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17. C. Rushton, "Respect in Critical Care—A Foundational Ethical Principle," *AACN Advanced Critical Care* 18, no. 2 (2007): 149-56.

18. Blair, Steiner, and Havranik, "Unconscious (Implicit) bias and Health Disparities," see note 1 above.

19. Reina, Reina, and Rushton, "Trust: The Foundation for Team Collaboration and Healthy Work Environments," see note 8 above.

20. C.H. Rushton and M. Adams, "Asking Ourselves and Others the Right Questions: A Vehicle for Understanding, Resolving, and Preventing Conflicts Between Clinicians and Patients and Families," *AACRN Advanced Critical Care* 20, no. 3 (2009): 295-300; D. Salani, "Implementation of Shift Report at the Bedside to Promote Patient- and Family Centered Care in Pediatric Critical Care Unit," *Journal for Nurses in Professional Development* 31, no. 2 (2015):81-6; T. Tidwell et al., "A Nursing Pilot Study on Bedside Reporting to Promote Best Practice and Patient/Family-Centered Care," *Journal of Neuroscience Nursing* 43, no. 4 (August 2011): E1-5.

21. Tidwell et al., "A Nursing Pilot Study," see note 20 above.

22. Salani, "Implementation of Shift Report," see note 20 above.

23. Reina, Reina, and Rushton, "Trust: The Foundation for Team Collaboration and Healthy Work Environments," see note 8 above.

24. Rushton, "Ethics of Nursing Shift Report," see note 4 above.