



Information concerning ICU patients' families in the handover—*The clinicians' «game of whispers»*: A qualitative study

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Abstract

Aims and objectives: To explore how information concerning ICU patients' families is included in the ICU clinicians' daily handover.

Background: Handover refers to the transfer of information and care responsibility between clinicians. An effective and precise handover are of great importance to ensure quality of care. Although improvements in handovers have received increasing attention in recent decades, little is known about how information about ICU patients' family members is included in handovers.

Design: A qualitative study using Charmaz' constructivist grounded theory approach.

Methods: Data were gathered through participant observation, focus groups, dyadic and individual interviews of physicians and nurses from four ICUs in different Norwegian hospitals. The data consist of 270 observation hours, seven focus groups, three dyadic interviews and two individual interviews. Field notes and transcribed interview data were analysed using constructivist grounded theory approach. COREQ checklist was applied as reporting guideline for this study.

Findings: "A game of whispers" emerged as the core category, representing missing information about the patient's family during the handover. Together with three sub-categories: "documentation dilemmas," "being updated" and "talking together," the core category explains how transfer of family-related information between clinicians is continually processed and resolved.

Conclusions: This study indicates challenges related to appropriate and high-quality handover concerning ICU patients' families. Oral handovers are essential in terms of clinicians' need to elaborate on written information and update each other. However, oral transmission involves a high risk of information loss during the handover. Written documentation about the family seems to be inadequate and poorly structured.

Relevance to clinical practice: The study findings suggest a need for increased awareness in practice and research of the importance of transferring appropriate and reliable information about patients' families between ICU clinicians. User-friendly

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handover tools and patient records that include information on patients' family members should be developed.

KEYWORDS

constructivist grounded theory, family, handover, Intensive care, patient- and family-centred care, qualitative research

1 | INTRODUCTION

A handover is defined as “an explicit transfer of information between clinicians” (Abraham, Kannampallil, & Patel, 2012). Through the handover, professional responsibility and accountability for the patient are transferred from one clinician or a professional group to another (Bakon, Wirihana, Christensen, & Craft, 2017; Merten, Van Galen, & Wagner, 2017; Smeulers, Lucas, & Vermeulen, 2014). To ensure effective and safe patient care, the information transfer must ideally contain all relevant information about the patient (Merten et al., 2017). This also includes information about the patient's family. The family is a fundamental resource and caregiver for the patient and an important collaborator for the health professionals (Davidson et al., 2017). This is especially important in an intensive care setting as most ICU patients are too ill or affected by medication to contribute to their own care and decision-making. For the ICU patient's family, there is also a serious mental strain when a close family member becomes critically ill (Davidson et al., 2017; Mitchell & Wilson, 2019). Consequently, they also need care and information from the clinicians in the ICU team. To ensure continuity and quality of family care, it is necessary to include information about the ICU patient's family in the handover. Improvements in handovers have received increasing attention in recent years in order to enhance quality in communication and continuity of care (Hoskote et al., 2017; Smeulers et al., 2014). These improvements include face-to-face communication, structured documentation, patient involvement and use of information technology to support the process (Smeulers et al., 2014). Despite this, some aspects of handovers remain unexplored and appear suboptimal. To our knowledge, few studies have explored how information about ICU patients' family members is included in handovers. Kowitlawakul et al. (2015) showed that only 41% of physicians and nurses included information about the patient's family in the handover when transferring patients in or out of the ICU.

1.1 | Background

In addition to taking care of the patient, ICU nurses and physicians are responsible for helping the patient's family cope during the patient's ICU-stay and working to reduce the risk of stress-related reactions for the family (Mitchell & Wilson, 2019). This requires that information from and about the family is transferred between health professionals. Close family members know the patient well

What does this study contribute to the wider global clinical community?

- Handover including the ICU patient's family is not emphasised in previous research despite family care being an essential part of the ICU team's daily work.
- Oral handovers are essential in terms of clinicians' need to elaborate on the information and update each other, including details about the family. At the same time, oral transmission involves a high risk of information being altered or lost.
- There is a need for user-friendly handover tools and patient records that include information about patients' family members.

and should be acknowledged as essential resources in the care of the patient as they commonly are supportive and represent hope and safety (Alexandersen et al., 2019; Haugdahl et al., 2018). In addition, family members have their own needs. They are at high risk of developing psychosocial symptoms such as sleep disorder (Choi et al., 2016), depression, anxiety, posttraumatic stress disorder and complicated grief (van Beusekom, Bakhshi-Raiez, de Keizer, Dongelmans, & van der Schaaf, 2016; Davidson, Jones, & Bienvenu, 2012) and decreased health-related quality of life during the period of critical illness (van Beusekom et al., 2016). Family members need access to ICU to ensure their proximity to the patient and to receive thorough and honest information about the patient's condition (Briggs, 2017; Frivold, Slettebo, & Dale, 2016). Inadequate communication and inconsistent information from ICU nurses and physicians are often the main cause of dissatisfaction in families of ICU patients (Frivold et al., 2016; Jensen et al., 2017). This suggests that the ICU team need to improve their communication and cooperation regarding these families.

The ICU team consists first and foremost of nurses and physicians from the ICU, but the extended team includes health professionals from different disciplines such as physicians from other specialties, physiotherapists, social workers and chaplains (Bjurling-Sjöberg, Wadensten, Pöder, Jansson, & Nordgren, 2017; Donovan et al., 2018). The ICU handover characteristically involves reporting of high medical complexity due to the patient's critical illness and information about the technologically advanced medical equipment in use (Kowitlawakul

et al., 2015). Effective information sharing is essential for an efficient ICU team (Ervin, Kahn, Cohen, & Weingart, 2018). ICU handovers regularly take place several times a day due to changes in medical or nursing shifts, and during transfer of patients in and out of ICU (Rodríguez et al., 2018). Handovers are both intra-disciplinary between nurses or physicians in the shift change and inter-disciplinary between physicians and nurses, for example during rounds. These formal handovers are supplemented with informal information-sharing throughout the day as needed (Ervin et al., 2018).

In general, written notes in the patient record support oral handovers (Collins et al., 2011; Ervin et al., 2018; McFetridge, Gillespie, Goode, & Melby, 2007; Smeulers et al., 2014). Use of checklists, guidelines or other suitable tools is recommended to ensure an effective and structured handover (Bakon et al., 2017; Dutra, Monteiro, Ribeiro, Schettino, & Kajdacsy-Balla Amaral, 2018; Smeulers et al., 2014). These are designed to promote effective communication among clinicians and to rationalise care (Ervin et al., 2018). However, use of these tools is criticised for making the handover too rigid and standardised, risking losing a holistic and individual perspective on care (Hillgoss & Moffatt-Bruce, 2014; Rodríguez et al., 2018; Spooner, Aitken, & Chaboyer, 2018).

ICU handovers generally take place at the bedside or in the clinicians' daily meetings (Ervin et al., 2018). To enhance collaboration and information flow between clinicians and family, it is recommended that family members are present during the bedside handover (Ervin et al., 2018; McCloskey, Furlong, & Hansen, 2019). This is in line with the principles and approach of patient- and family-centred care (PFCC) which recommends that health care be respectful and responsive to patients' and families' values and needs (Davidson et al., 2017; IPFCC, 2010). It might, however, be challenging to allow family presence in the handovers due to the clinicians' need for undisturbed medical discussion and confidentiality in multi-bedded rooms (Davidson et al., 2017; Ervin et al., 2018).

Intensive care is event-driven and time-pressured (Merten et al., 2017) and interruptions and distractions during handovers are common (Ganz et al., 2015; Kowitlawakul et al., 2015; Spooner, Corley, Chaboyer, Hammond, & Fraser, 2015). Further, the ICU team is seldom constant. Due to shift work, in-service training and dynamic changes in patient needs, team members may change from day to day (Bjurling-Sjöberg et al., 2017; Ervin et al., 2018; Hoskote et al., 2017). This instability results in challenging handovers and disruptions in continuity of care for patients and their families.

Although we have a broad picture of clinicians' communication with ICU families (Davidson et al., 2017), there are still knowledge gaps regarding how information *about* the family is included in ICU clinicians' daily handover.

1.2 | Aim

The aim of this study is to explore how information concerning ICU patients' families is included in the ICU clinicians' daily handover.

2 | METHODS

2.1 | Design

A constructivist grounded theory approach was used to explore how ICU clinicians communicate about the patients' families in their everyday practice. According to Charmaz (2014), grounded theory is well suited to investigate both individual and collective actions, and interactions between participants (Charmaz, 2014). The aim of this approach is to conceptualise and understand participants' behaviour and meanings in a particular setting (Charmaz, 2014; Giles, de Lacey, & Muir-Cochrane, 2016). In grounded theory methodology, inductive and abductive strategies are combined to develop theory grounded in data. The researcher seeks out the main concern of the participants using systematic yet flexible guidelines to form conceptual categories (Thornberg & Charmaz, 2014).

Essential principles in grounded theory are simultaneous data collection and analysis, constant comparative method, theoretical sampling and saturation together with memo writing (Charmaz, 2014; Thornberg & Charmaz, 2014). In grounded theory, the researcher has to choose data collection methods based on the research problem and the on-going data analysis (Thornberg & Charmaz, 2014). In this study, participant observation, focus groups, dyadic and individual interviews were chosen.

Constructivist grounded theory has roots in pragmatism and relativist epistemology (Charmaz, 2016; Thornberg & Charmaz, 2014). Knowledge is seen as socially produced, and multiple realities are acknowledged (Charmaz, 2016). Constructivism brings out subjectivity and interaction; neither the data nor the analysis is considered neutral (Charmaz, 2016). The researcher and the participants are perceived as co-constructors of data, influenced by the researcher's interactions with the participants, their perspective and their research practice (Charmaz, 2016; Giles et al., 2016). The method emphasises researchers' reflexivity and awareness throughout the research process (Thornberg & Charmaz, 2014).

The "consolidated criteria for reporting qualitative research (COREQ)"—checklist (Tong, Sainsbury, & Craig, 2007) was applied as the reporting guideline for this study (Supporting information File S1).

2.2 | Setting and participants

Data were gathered at four ICUs in different Norwegian hospitals—three university hospitals and one mid-range hospital. These ICUs treat both medical and surgical critically ill patients, adults and children. Size ranged from 6 to 18 beds; two had only single rooms, while the others had both single rooms and rooms with 2–4 beds. The nurse–patient ratio was 1:1.

In Norway, close family have legal rights to be informed and included in the care and treatment of the patient. However, they do not have a right to act as a surrogate on behalf of the patient. Patients themselves can decide who should be considered as their

family. These persons do not necessarily have to be biological or legal family (The Health Personnel Act, 1999).

In this study, ICU nurses and physicians were the study participants of interest. During data collection and analysis, preliminary findings showed that physicians from the patients' surgical or medical ward were jointly responsible with the ICU staff for providing family members with information and were often involved in the ICU team's handover. They were therefore included in the study.

All nurses and physicians in the participating ICUs agreed to be observed during the fieldwork. To make a thorough observation of the handover, the researcher observed one ICU team daily by following their treatment and care of one or two ICU patients and their families. The observation was continued with the same team, patient and family for one to three shifts before turning to observe another team. The observations typically focused on handover situations in the patient's room and during the clinicians' meetings throughout the shift. Such situations were, for example, nurses' shift reports to another nurse, physicians' daily morning meetings, preround meetings, meetings during rounds and other interdisciplinary meetings. However, nurses and physicians were, in addition, observed during informal meetings, such as dialogues about family care during lunch breaks. With the consent of families and patients (if capable), the researcher also observed when families were visiting and their encounters with the clinicians.

The participants in the focus groups were ICU nurses and physicians; they were colleagues and worked in the same ICU. The participants in the dyadic and individual interviews were surgeons and internists. They knew each other, but belonged to different ward units in the same hospital. In total, 40 clinicians participated in focus groups and interviews: 19 ICU nurses, 13 ICU physicians (Table 1) and eight surgeons/internists (Table 2). As far as possible, participants with different ages, gender and experience were invited to participate. No ICU leaders participated in the focus groups or during the interviews, however, as part of the fieldwork, the observer spoke with both the nurse and the physician in charge of each ICU.

2.3 | Ethical approval

The study was approved by a formal institutional ethics review board (Regional Committee for Medical and Health Research

Ethics - Ref.: 2016/1762), and by the participating ICUs. In each unit, the researcher (AMN) was provided with a contact nurse who forwarded information on the study to the ICU nurses and physicians before the fieldwork started. The researcher also informed the clinicians orally at every shift. Although clinicians, rather than patients and family members, were the participants in this study, it was impossible to observe clinicians in the patient's room without simultaneously observing patient and the family. Thus, oral information about the project was provided to alert and consenting ICU patients and to all family members present. Neither patients nor family members refused to have the researcher present. Written information about the project, with a photograph of the researcher, aimed at informing visiting clinicians and all visiting family members was posted at the ICU entrance and in the ICU corridors. Written informed consent was obtained from the participants in the interviews. In the written and oral information, the researcher explained the background, purpose, duration and confidentiality of the study, and about the participants' right to withdraw from the study at any time. The researcher's contact information was included in the written information.

The researcher assured the participants of confidentiality and anonymity. In focus groups, this can be difficult as the researcher has limited control over the participants after the interview (Sim & Waterfield, 2019). At the beginning of each focus group and dyadic interview, the moderator encouraged the participants not to communicate any of the topics discussed outside the group. To protect confidentiality, all transcriptions from field notes and interviews were anonymised.

2.4 | Data collection

Data were collected using a variety of methods and according to the principle of theoretical sampling. Theoretical sampling refers to (Glaser & Strauss, 1967):

the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them.

TABLE 1 Focus group participant characteristics

Focus group (N = 7)	Focus g. 1	Focus g.2	Focus g. 3	Focus g. 4	Focus g. 5	Focus g. 6	Focus g. 7
Hospital No.	1	1	2	2	3	4	4
Mid-range (M)/ University (U)	M	M	U	U	U	U	U
Intensivists	0	4	0	5	2	2	0
ICU nurses	3	0	5	0	3	3	5
Gender—female/male	2/1	0/4	3/2	1/4	2/3	2/3	5/0
Age—range	37–54	34–60	28–54	33–67	39–49	37–54	34–60
ICU experience—mean (min-max)	17 (8–25)	14 (5–30)	10 (2–15)	23 (2–38)	12 (3–20)	10 (4–16)	8 (1–19)

TABLE 2 Participant characteristics for dyadic and individual interviews

Interviews Dyadic/individual	Interview 1 Dyadic	Interview 2 Dyadic	Interview 3 Individual	Interview 4 Dyadic	Interview 5 Individual
Hospital No.	3	3	4	4	4
Mid-range (M)/University (U)	U	U	U	U	U
Specialisation—surgeon/internist	2/0	1/1	1/0	0/2	0/1
Gender—female/male	0/2	1/1	1/0	1/1	1/0
Age—range	36–65				

All researchers (AMN, HSH, BSB, RL) are female nurses, including three ICU nurses, all with expertise in clinical practice and teaching. HSH, BSB, RL are widely experienced in qualitative research, leading focus group discussions and with doctoral (HSH, RL) or professorial expertise (BSB). BSB and RL started the data collection by conducting two focus groups in July and October 2017, one with ICU nurses and one with ICU physicians. The participants' concern about missing information about the ICU patient's family emerged as an initial code already from the analysis of the first focus group. To focus this code and gather richer data about the clinician's handover process, the researchers extended the data collection to participant observations (fieldwork) combined with focus groups. The preliminary data collection and analysis from the first two focus groups were also used to complete the study protocol and organise further steps to accomplish the study.

The fieldwork was performed (by AMN) between June 2018 and August 2019 in eleven to fourteen shifts in each of the three university hospital ICUs. Since the researcher who made the observations is an experienced ICU nurse, she was occasionally included in simple nursing care. This opportunity to follow ICU clinicians during their work enabled the observer to stay close to situations where family care was provided. The researcher made field notes throughout and following each shift.

During the last week in each ICU, focus groups were conducted (by AMN and HSH or RL), with ICU nurses only, with ICU physicians only, and with a mixture of nurses and physicians (Table 1). Each focus group consisted of five participants, except for the first two, which had three and four participants. With consideration to the inequalities of power (within a hierarchical structure) and to identify different perspectives between the nurses and physicians, the first focus groups were conducted with one profession at a time. Then, to explore the interaction and discussions between the professionals, the researchers conducted focus groups with nurses and physicians at hospitals 3 and 4. The researcher's contact nurse in each ICU recruited participants to the focus groups, face-to-face or by email.

When it became evident that physicians from the patients' surgical or medical ward were included in the ICU team's handover the data collection was then extended further by arranging five interviews (by AMN) with a total eight of these physicians at hospitals 3 and 4 (Table 2). We tried to schedule focus groups with these physicians as well but due to their busy working days in different clinics, it was not possible. Recruitment of these participants was arranged by email to the head of the surgical and medical clinics. The data

collection and analysis showed that nurses were more heavily involved in family care and included more information about the patient's family in their handovers than physicians. To make sure that the emerging conceptual categories were saturated, the researchers conducted one additional focus group in hospital 4 with ICU nurses only.

An interview guide designed as a "questioning route" (Krueger & Casey, 2015) was employed and modified during data generation and the development of codes and categories. All interviews took place in a separate meeting room in the ICUs. Two researchers, a moderator and an observer, conducted each focus group. The moderator chaired the focus group while the observer followed the interactions between the participants, made notes and provided a summary. The dyadic and individual interviews were conducted by AMN. All interviews were digitally recorded and transcribed verbatim by the first author. The data consists of field notes and transcriptions from 270 hr of observation and from twelve focus groups and interviews lasting from 37 to 96 min.

2.5 | Data analysis

Field notes and transcribed interview data were analysed using a constructivist grounded theory approach. In accordance with grounded theory, data collection and data analysis were conducted simultaneously (Thornberg & Charmaz, 2014). Immediately after each data collecting, the analysis and coding process began with line-by-line reading and initial coding of field notes and transcripts. Analytical questions were asked of the data (Charmaz, 2014): What is this data a study about? What do the data suggest, pronounce or leave unsaid? From whose point of view? What might his or her observed behaviour indicate? What is the participant's main concern? As a result of the initial coding, the most frequent and significant codes emerged and were constructed as focused codes. The data analysis was not linear, but a constant back and forth process comparing data, codes and categories, using constant comparative analysis (Charmaz, 2014; Thornberg & Charmaz, 2014). The analysis generated insights, assumptions, aha experiences and questions that the researchers brought to the next data collection. Through memo writing, the ideas about codes, emerging categories and the relationship between them were clarified and explicated. In this way, the level of abstraction increased, and conceptual categories were gradually

developed. One core category with three-related subcategories emerged, explaining the participants' main concern.

AMN coded all written text from interviews and field data and wrote memos. HSH, BSB and RL read the data material and contributed to the analysis. The researchers met several times to discuss, select and focus the codes. They contributed ideas and perspectives from their different disciplines, helping the team to identify conceptual categories.

2.6 | Findings

The core category "a game of whispers" first emerged as an in vivo code when a nurse in one of the first focus groups used the concept to describe what happens when information about the family changes with each new member of the ICU team who passes it on:

... often it's like a game of whispers; if you meet the nurse who was at the meeting with the relatives, you get a good report, but then you pass on the info to someone else and so on ... that doesn't work so well.

(Emma, ICU nurse, interview 3)

A game of whispers is a well-known children's game. One player whispers a message to a second, the second whispers to a third, and so on. Once the message has gone around everyone and returned to the one who started, it has changed along the way. This indicates how details about a patient's family members get lost during the "game." Only parts of the information will be carried over to the next shift. There is also lack of accurate written documentation about the ICU patient's families. Several nurses called attention to this problem in the focus groups. One of them expressed it like this:

.... we often read in the patient record that the family have talked to the physician and nurse, ...but about what? What did they talk about? That's not written anywhere. They got information, but what kind of information? That's what I miss ...

(Megan, ICU nurse, focus group 3)

Both oral and written information appeared to have shortcomings. The big picture is missing and ICU physicians and nurses do not receive the necessary information about the patient's family. Further analysis revealed that the information handover process was the participants' main concern. "A game of whispers" emerged as a core category, conceptualising the interdisciplinary interactions, meanings and actions attached to the handover about ICU patients' family members. During the analysis, from the initial coding to the development of the core category, three subcategories were identified and related to the core category: "documentation dilemmas," "being updated" and "talking together."

2.7 | Documentation dilemmas

Written information, primarily in the patient record, is an important part of the daily handover between health professionals. In this study, several dilemmas physicians and nurses face regarding written documentation about ICU patients' family appeared. The subcategory "documentation dilemmas" represents these dilemmas.

The analysis showed that most nurses were at pains to ensure that contact information for the patient's closest family members was correctly recorded in writing. This is essential because it informs decisions as to who is entitled to receive information about the patient, who should be contacted if needed and who is entitled to represent the patient. According to this, the nurses have the challenge of finding: "who actually is the patient's nearest (i.e. rightful) family," since many ICU patients are sedated or too ill to be able to name their nearest family. The nurses have to trust other sources such as the patient's family or previously documented information about the family in the patient records. This could be a dilemma. Nurses experienced that family members could provide them with conflicting information. Disagreements within the patient's family and/or new family relationships made this work even more challenging. "It depends on who you talk to," the nurses explained in bedside situations and during focus groups. It also appeared that the documentation in the patient record could be out-of-date:

An unconscious patient was transferred to the ICU from the ward as his condition was deteriorating. The patient's nurse repeatedly tried to ring the patient's mother as stated in the patient's record ... but got no answer. Later the patient's father arrived and revealed that the patient's mother died two years earlier. The nurses describe the situation as very embarrassing and unpleasant.

(Field note from ICU 4)

Such mistakes are not just embarrassing and unpleasant for the nurses. They can undermine confidence or result in conflicts between clinicians and the family. For nurses, it clearly represented a dilemma between safeguarding the rights of the patient's family and, at the same time, protecting the patient from unauthorised access to patient information or acting against his/her wishes.

I've been in situations where there was a family conflict and when the patient woke up, it turned out that the person who was given information definitely shouldn't have got it.

(Karen, ICU nurse, focus group 1)

Another dilemma concerning written information was *how, what and which* information about the ICU patient's family the clinicians ought to document. Beyond formal details, the patient record contained little information about the patient's family. Although nurses

and physicians are involved daily in family care, this work is scarcely visible in the written documentation. The patient record often contains only a brief note or a ticked box to say, "the family have been informed" or, "the family have visited the patient." Clinicians argued that it is the patient's record and it is unclear to what extent information about the family actually belongs there. In some patient record systems, there is a separate file to record "information to and from family members." However, this file was rarely used. In the focus groups and the dyadic interviews, the clinicians discussed possible explanations. Some meant that the document is too comprehensive, others were unaware that it existed. In addition, the participants described conflicting views on how and when to use the file. These findings revealed that documentation practices about patients' families vary among clinicians, which can result in missing information. Lack of consensus about a suitable documentation strategy was experienced as a personal and systemic weakness. The dilemma is about how to find a common way of documenting information about the family in a clear and easily accessible manner without using too many words:

It's an advantage if everyone (i.e. the physicians and nurses) has the same idea of how to do it, so that everyone knows where to look or where to write and when to write it or what to write ... so there isn't a lot of writing just for the sake of writing.

(Hans, ICU nurse, focus group 3)

The field observations showed that the family members' reactions and emotions are rarely documented in writing. A common understanding was that such sensory impressions might be challenging to express in a formal, objective way. When experiencing these documentation challenges, it seemed that clinicians just avoided writing anything at all to prevent being misunderstood or misinterpreted. Both physicians and nurses emphasised that the patient and the family (if they had legal access) should have the possibility of reading the patients' record without facing negative or disrespectful content. Thus, they merely communicated the information orally:

...so many ... things are said that we can't just note down in the patient record.

(Eric, senior intensivist, focus group 5)

Yes, we're very careful when writing anything about relatives, we're almost a bit nervous about writing, I think that goes for all of us nurses, we write very little. If there are conflicts, we certainly don't write about it, [...] I sometimes think it's a bit arbitrary what you write.

(Lilly, ICU nurse, focus group 5)

Patients' ability to log in to their patient record (from home) is a relatively new opportunity in Norway. This subject generated a lot of discussion in the focus groups and seemed to have an impact on

the participants' willingness to report information about the family in written. Some participants had found that the closest family member provided with the patient's login code had gained access to the patient record system. Just a few participants had heard of or experienced such situations. However, these stories really engaged the participants. Their common opinion was that family members' access to the patient's record influenced the clinicians to be more restrictive and careful with their documentation practices.

On the other hand, the participants recognised the legal value of the documentation as being important for the daily transfer of information, but also for recording purposes. One of the surgeons explained that for them as a profession thorough documentation of family information and of their understanding of the facts was of utmost importance as a quality- and safety assurance of their work. They would never risk later meeting families who retrospectively said; "Nobody told us."

2.8 | Being updated

The subcategory "being updated" reflects the importance of clinicians' internal communication of up-to-date and correct information concerning the patient's family. Being updated is fundamental to their ability to pass on consistent information:

It's desperately important to agree on what we say to the family and that we know what the physicians from the patient's ward unit has said.

(David, senior intensivist, focus group 6)

Being updated is also crucial for the ICU clinicians to function coherently and work as a professional team. It demonstrates interdisciplinary team working and cooperation to the family.

However, this study revealed a discrepancy between the professionals in their desire to be updated: nurses had a greater need to know what physicians told the family than vice versa. Physicians generally inform the family about the patient's diagnosis, prognosis, treatment and the results of various tests. The fieldwork displayed that it was common practice for nurses to attend physicians' formal information meetings with the family. Both physicians and nurses emphasised the practice as a necessity. Nurses should participate as they later have to repeat the information to the family and clarify it for them. The challenge, however, is to keep the rest of the nurses in the ICU team updated as the information was generally just oral and this "game of whispers" could lead to loss of important information.

The physicians usually documented the content of information provided to the family only when they had informed them about something particularly serious or important, such as withdrawing or withholding treatment. Information about everyday ICU issues was considered by the physicians to be familiar to everyone in the team and was usually not documented. On the other hand, the nurses said that they generally needed to know about all aspects of the physician's conversation with the families. In particular, they appreciated

being informed if the physician had withheld any information from the family. Without this information the nurses often had to “put on a brave face” in their conversations with the family. They became insecure, vague and afraid to say something wrong. The nurses emphasised that they wanted to be honest, without going beyond their area of responsibility.

The fieldwork showed that nurses provide the family with different kinds of information, without the physician being present. Examples of this are information about the patient's condition and daily treatment plans. In addition, nurses take responsibility for establishing a safe interpersonal climate towards the family, with trust as a cornerstone. In such a trustful relationship, they commonly engaged in small talk and counselling. This kind of information, and other practicalities within their profession, seemed to be of lesser importance in the nurses' handovers and little of this information was documented.

Updates within the ICU team regarding practical information concerning the family, such as agreements and messages (to/from the family), also seemed to be less emphasised. This can cause the flow of information between clinicians to be broken and prevent essential information from reaching the patient's family:

During the morning report, the day shift nurse asked the nurse from the night shift whether the patient's wife had been told that he had been admitted to the ICU instead of the post-operative ward. The patient needed to be ventilated overnight. The nurse said she did not know if the wife had been informed. Nothing of this was documented in the patient's record or chart.

(Field note, ICU 3)

2.9 | Talking together

The subcategory “talking together” shows the value of physician' and nurses communication in the ICU team. Their talk is crucial for the team to reach agreement and create continuity in family care. Both fieldwork and focus groups showed that physicians and nurses needed to talk together, especially in the case of challenging and serious patient situations or in situations with conflicts with the family, or among them:

If it is difficult to please the family members [...] or if there's a conflict between the family and us, we actually discuss it. We help each other.

(Christian, intensivist, focus group 2)

The ICU team has daily inter-disciplinary and intra-disciplinary handovers where the clinicians have the opportunity of talking together. Clinicians' team conversations and discussions allow information exchange and give them opportunities to achieve a common

understanding and consensus. The issues raised are often serious and complex.

The nurses had their handover at the bedside. They more or less always include oral information about the ICU patient's family. The amount of information varies between situations and from nurse to nurse. Nevertheless, nurses as a profession, due to their extensive daily contact and conversations with the family, were talking more about the patient's family than did the physicians. The nurses described themselves as “a buffer” for the need to involve physicians in family issues, and they decided when to involve a physician. Examples of such situations were when a family member raised questions about medical or prognostic issues beyond the nurses' responsibilities, or when a conflict with the family occurred to be in the offing.

The physicians had their daily handover in a meeting room within the ICU. Sometimes, especially in one of the ICUs, the whole group of physicians carried out their handover during the bedside rounds. The fieldwork showed that the physicians (unlike the nurses) did not regularly include information about the patient's family in their daily handover. The physicians emphasised that they could not spend time on such issues unless there was an extraordinary situation that justified bringing family issues into the agenda. In one focus group, a physician explained that:

Usually we only talk about family members if someone is angry or has complaints about something, or if it is a difficult situation and we know that this will be troublesome for our colleagues. Beyond this it is not a topic.

(Tom, intensivist, focus group 5)

The fieldwork also confirmed that physicians in situations such as end-of-life discussions or other critical and serious situations discussed family-related questions during handover.

The most important inter-disciplinary handover among the nurses and physicians was the daily bedside round. In these handover situations, as well, it varied whether the clinicians were talking about the patient's family or not. Most often, the nurses were those who included aspects relating to families in the ICU teams' discussions during rounds. However, in the focus groups both physicians and nurses expressed their need for more inter-professional communication about the ICU patient's family. During discussion in one of the mixed focus groups, the nurses suggested that family issues should be a “fixed point” of the daily round. Apart from the patient record and chart, neither the nurses nor the physicians appeared to use any kind of structured handover guidelines or tools.

Observations from the fieldwork showed that both physicians and nurses needed to supplement formal meetings with more informal conversations about the family. The need for talking together was often context-dependent and difficult to plan ahead of the meeting. Such conversations occurred spontaneously when a

clinician needed to inform, discuss or consult colleagues. These conversations could take place during lunch break, in the corridor or in the patient room when the family was not present.

During the fieldwork, I noted that physicians and nurses often made use of their lunchbreak in order to speak about a question or topic related to the patient's family or next of kin. *Talking together* is clearly vital. This implies that the formal meetings such as the ward round and the bedside handover do not go far enough to cover this need to *talk together*. Less formal conversations during lunch satisfy the need for off the cuff conversation especially regarding demanding and often unforeseen situations that arise with regard to the patient and their family. My impression is that there is a general willingness to take up such matters despite this being the clinic's 'free time'.

(Excerpt from memo: 'Talking together')

These informal conversations contained frustration, helplessness and irritation, but also joy. They served as an outlet for clinicians' feelings. Sharing thoughts and listening to good advice and simply the opinions of others reassured them and made them feel better equipped to talk to the family. However, the challenge for physicians and nurses is to find space for talking together under the pressure of limited time, unforeseen incidents and constant interruptions.

The fieldwork showed that bedside handovers and rounds were common practice in the ICUs, but that the patient's family were usually not present. This was also the case in the ICUs with only single bedrooms and with flexible visiting hours. Clinicians mainly justified this on the grounds of efficiency and of their need to speak to their colleagues confidentially and without interruption.

3 | DISCUSSION

In this qualitative study, we wished to explore ICU nurses' and physicians' handovers concerning ICU patients' families. The core category "a game of whispers" and its three-related subcategories "documentation dilemmas," "being updated" and "talking together," explains how the participant's main concern about transfer of family-related information between clinicians is continually processed and resolved. Information about the patient's family disappeared as if in a "game of whispers" during the handover process. Our findings show that written information about ICU patients' families was sparse, leaving the next shift with fragmented and inaccurate oral information. There was no agreement between the professionals on how family care and information about the family should be documented and reported. Even if improvements in handover have received increased attention in recent times, these findings indicate that routines for how information about the family should be included in the ICU teams' handover are missing, leaving scope for improvement. Earlier research shows the importance of effective and

safe handover (Hoskote et al., 2017; McCloskey et al., 2019), which is associated with good workflow, increased focus on patient safety and efficient use of healthcare resources (Abraham et al., 2012; McCloskey et al., 2019).

Lost or inaccurate information is a well-known problem in clinical handovers both within ICU and during transfers between ICU and other hospital ward units (Blum & Tremper, 2009; Dutra et al., 2018; Enger & Andershed, 2018; Ganz et al., 2015; Zakrisson et al., 2016). Incomplete handover is associated with medical errors and inadequate care (McCloskey et al., 2019; Smeulders et al., 2014). Our findings indicate that when the information handover within the ICU was lacking about family issues, family members were less likely to receive consistent information from the ICU team. Poor patient- and family-centred care might be the outcome.

Although oral handover has its weaknesses, it also has an important advantage. This study shows that ICU nurses and physicians need to "talk together" and "be updated" to create continuity in the treatment team, establish a common strategy and be consistent when communicating with the family. The findings concur with other studies in showing that oral handovers allow clinicians to inform, ask, discuss and reflect together (Cohen, Hilligoss, & Kajdacsy-Balla Amaral, 2012; Hilligoss & Moffatt-Bruce, 2014; Poletick & Holly, 2010). Handovers may also function as briefing, debriefing, training, and experience exchanges between health professionals (Bakon et al., 2017; Poletick & Holly, 2010). The study participants emphasised that the need to talk together and be updated is greatest in demanding and complex situations with family members. According to Cohen et al. (2012), transmission of information should not resemble a telegram that passes a message passively from one person to another. On the contrary, handovers should be co-constructed and an active process of two-way communication (Blum & Tremper, 2009; Hilligoss & Moffatt-Bruce, 2014). Narratives offer a more detailed and comprehensive understanding of a situation. With narratives, the context is taken into account and critical thinking given space, especially important in complex situations (Hilligoss & Moffatt-Bruce, 2014). This concurs with findings in the present study showing that the participants, in particularly challenging complex situations and otherwise as needed, came together in informal meetings to talk about the actual situation, seeking mutual help and advice.

Oral handovers should be combined with structured documentation (Blum & Tremper, 2009; Smeulders et al., 2014; Zakrisson et al., 2016). The patient record is an important tool for creating information flow and communication between health professionals (Collins et al., 2011; Nelson, Walker, Luhrs, Cortez, & Pronovost, 2009). It can also be a tool to structure handovers and make them more effective (Kowitlawakul et al., 2015). This study revealed that many ICU nurses and physicians used information from the patient's record during the oral handover. Similarly, Kowitlawakul et al. (2015) found that up to 70% of physicians and nurses used the patient record in handovers. However, in relation to family care, the problem, as this study shows, is that the record contains limited

information about the patient's family. Nelson et al. (2009) recommend that information about the family is always to be written as a separate entry in the patient record. This provides important information to clinicians who were not present and thus enhance continuity of family care (Nelson et al., 2009). This is also in line with Norwegian legislation regarding patient records, which states that information and advice given to the family must be documented in the patient record (The Health Personnel Act, 1999). The patient record also serves as evidential documentation of the healthcare services provided.

Collin et al. (2011) argue that an inefficient and user-unfriendly patient record system can make clinicians rely more on oral than on written information. This agrees with our findings that the participants did not fully utilise the medical record system and that there were little agreement and structure regarding what should be documented about the patient's family, how and by whom. The dilemmas that arose in relation to how to document information about family members made health professionals communicate this information orally. This lack of documentation means that the considerable time and resources spent by the physicians and nurses in ICU in fulfilling their responsibility for the care of the patient's family goes unrecorded and is more or less invisible.

To ensure effective and structured high-quality transmission of information, handover tools, guidelines or checklists are recommended (Abraham, Kannampallil, Almoosa, Patel, & Patel, 2014; Blum & Tremper, 2009; Graan, Botti, Wood, & Redley, 2016; Hoskote et al., 2017; Kowitlawakul et al., 2015; Merten et al., 2017; dos Santos, Campos, & da Silva, 2018). No such tools were used by the participants in this study. The use of handover tools can save time and prevent large variations in clinicians' handover practices (Hilligoss & Moffatt-Bruce, 2014; dos Santos et al., 2018). However, the design of these tools has been criticised for being too rigid or too extensive (Abraham et al., 2014; Hilligoss & Moffatt-Bruce, 2014; Spooner et al., 2018). In both cases, there is a risk that information transfer between health professionals will be incomplete, with the loss of key information (Abraham et al., 2014). Specific information about the family also appears to play a minor role in such standardised tools (Bakon et al., 2017; Nasarwanji, Badir, & Gurses, 2016; Spooner et al., 2018). The omission of information about the patient's family may thus compromise the holistic patient- and family-centred care perspective (Hilligoss & Moffatt-Bruce, 2014).

In line with the principles for patient- and family-centred care, it is recommended that members of the patient's family are present during bedside handovers (Manias, Geddes, Watson, Jones, & Della, 2016; McCloskey et al., 2019) and during rounds (Davidson et al., 2017; Mørk, Krupp, Hankwitz, & Malec, 2018). This can enhance information flow between the clinicians and the family (Davidson et al., 2017; Ervin et al., 2018) and increase patient and family satisfaction (McCloskey et al., 2019). However, this study showed in accordance with Ganz et al. (2015), that having family members present during handovers was not common. In many clinicians' opinion, presence of family

members during handover can be too time consuming, lead to more interruptions and disturb medical discussion and reflection (Davidson et al., 2017; Ervin et al., 2018; Manias et al., 2016). Consideration for other patients and the need for medical confidentiality are also important factors in determining whether the family can be present during handovers (Davidson et al., 2017; McCloskey et al., 2019). This also concurs with the findings in the present study. However, it is surprising that even the ICUs with only single rooms and with flexible visiting hours usually had restrictions on having visitors present during bedside handovers and rounds.

4 | LIMITATIONS

Although various opinions on written documentation about the family emerged during data collection, no systematic document analysis was performed to explore this further. This could have been done in accordance with the grounded theory principle of theoretical sampling and may well have strengthened the study's findings. However, during the fieldwork, observations were made when clinicians made entries in the patient record. The impression from these observations was elaborated in the interviews. The findings from the fieldwork corresponded with the participants' statements during the interviews. The focus groups consisted of five participants, except for the two first focus groups with three and four participants, respectively. Fewer than five participants may be considered too few in a focus group. Other clinicians were invited, but their busy schedule did not allow them to participate.

One challenge for a researcher is to remember all the sayings and doings during observations. This is particularly difficult in a busy and noisy ICU. The researcher runs the risk of not catching all the details, forgetting what was said and misunderstanding observed situations. Therefore, the researcher asked for details and clarifications during the fieldwork and wrote field notes during and after each shift. The researcher also asked questions under the interviews to have her impressions and interpretations from the fieldwork confirmed or rejected. Through the memos, ideas, assumptions and decision-making during the whole research process were documented. A further advantage is that the researcher is an experienced ICU nurse with sound knowledge of ICU practice.

One nurse from each ICU recruited participants to the interviews. The sample may have been somewhat biased, since those ICU physicians and nurses who are most interested in family care may have been more likely to agree to participate. However, observations during fieldwork enabled the researcher to study variations in clinicians' family care, thus providing rich data. Due to research ethics considerations for patients, relatives and health professionals, a few situations arose where the researcher was unable to observe. This could have been because the staff did not want the researcher to observe or because she did not request this herself. Despite the exclusion these situations from the observations the fieldwork gathered rich data.

The researchers who moderated and observed the focus groups were familiar with ICU. It is helpful that an observer notes interactions while the moderator leads the conversation, encourages speaking freely and discussion, encouraging full participation by directing questions at some of the group members. Both moderator and observer were, in the mixed groups, mindful of the power imbalance and hierarchical relationship between nurses and physicians. Age and experience also influenced group dynamics. The group members knew each other and created a collegial atmosphere.

One former relative and one former ICU patient (with valuable experience from his family members) contributed as users in preparation of the study protocol and to the development of codes.

5 | CONCLUSION

The aim of this study was to explore nurses' and physicians' transfer of information concerning ICU patients' family members during handovers. The findings indicate challenges related to appropriate and high-quality transmission of family-related information between clinicians. Such information was mainly communicated orally. Oral handovers are essential in terms of clinicians' need to elaborate on the information and update each other, including details about the family. At the same time, oral transmission involved a high risk of information being altered or lost as in a "game of whispers." In addition, the study showed that written documentation about the ICU patient's family was inadequate and poorly structured.

5.1 | Recommendations for clinical practice and policy

It appears that few previous studies have emphasised how information about patients' family is transferred between ICU clinicians. The findings of this study suggest a need for increased awareness in practice and research of appropriate and reliable information transfer in the ICU context. User-friendly handover tools and patient records that include information on patients' family members should be developed.

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CONFLICT OF INTEREST

The authors declare no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

AUTHOR CONTRIBUTIONS

RL and BSB designed of the study. AMN, RL, BSB and HSH collected, analysed and interpreted the data. AMN drafted the manuscript. All authors critically revised the manuscript, gave final approval, and agree to be accountable for all aspects of the work to ensure its integrity and accuracy.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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