



# Is privacy a problem during bedside handovers? A practice-oriented discussion paper

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## Abstract

Bedside handover is the delivery of the nurse-to-nurse handover at the patient's bedside. Although increasingly used in nursing, nurses report many barriers for delivering the bedside handover. Among these barriers is the possibility of breaching the patient's privacy. By referring to this concept, nurses add a legal and ethical dimension to the delivery of the bedside handover, making implementation of the method difficult or even impossible. In this discussion article, the concept of privacy during handovers is being discussed by use of observations, interviews with nurses, and interviews with patients. These findings are combined with international literature from a narrative review on the topic. We provide a practice-oriented answer in which two mutually exclusive possibilities are discussed. If bedside handover does pose problems concerning privacy, this situation is not unique in healthcare and measures can be taken during the bedside handover to safeguard the patient. If bedside handover does not pose problems concerning privacy, privacy is misused by nurses to hide professional uncertainties and/or a reluctance toward patient participation. Therefore, a possible breach of privacy—whether a justified argument or not—is not a reason for not delivering the bedside handover.

## Keywords

Bedside handover, nursing practice, privacy, professional issues, semi-private rooms

## Introduction

Over the past two decades, patient participation has become an important paradigm in healthcare, supported by policymakers such as *BMJ*<sup>1</sup> and World Health Organization (WHO).<sup>2</sup> Patient participation is presented as a positive factor for patient safety<sup>3</sup> and quality of care<sup>4</sup> and is believed to be essential for the sustainability of healthcare systems.<sup>5</sup> According to Castro et al.,<sup>4</sup> patient participation is the strategy to evolve toward a patient-centered organization with patient empowerment as the main focus. These ideas resulted in an increasing number of methods and initiatives to involve patients. But, although patient participation is defined as “the blockbuster drug of the 21st century,”<sup>6</sup> concerns start to arise about the possible conflicting interests of patients and healthcare workers when these “patient-centered” initiatives are introduced.<sup>7,8</sup>

One example of these evolutions is the bedside handover, a process in which the nurses' shift-to-shift report is delivered at the patient's bedside.<sup>9,10</sup> Bedside handovers are a logical and efficient method as they combine the nurse-to-nurse handover with nurse-to-patient information provision. This process improves communication between nurses, and between patient and nurse, reducing safety incidents.<sup>9,11</sup> The method also leads to increased patient participation, improved patient-centeredness, enhanced patient empowerment, and augmented patient autonomy because the expertise and knowledge of nurses are shared with the patient.<sup>3,4,12</sup>

However, despite these benefits and the increasing interest in this method, use in practice remains limited. Several systematic reviews have consistently identified nurse-reported barriers for using bedside handovers,<sup>9,13,14</sup> leading to complicated or discontinued implementation processes. While most of these barriers are of a practical nature (e.g. duration or organization), one barrier relates to the possible breach of the patient's privacy and confidentiality while delivering the bedside handover in a semi-private room. While barriers of a more practical nature are resolvable by solution-oriented thinking, the possible breach of privacy and confidentiality adds an ethical and legal question to the use of bedside handovers, making implementation difficult or impossible.<sup>13,15</sup>

In our ongoing study on bedside handovers,<sup>16</sup> we identified the possible infringement of privacy as the nurses' most persistent argument against bedside handovers and could not find a practical solution in literature. Puzzled by this question, we purposefully explored the data from our ongoing study to look at this apparent conundrum from different perspectives. Although not the primary aim of our study, the mixed methods data from different settings and stakeholders enabled us to discuss this issue in-depth and formulate a practical answer. During this discussion article, the term privacy will be—although they are not similar<sup>17</sup>—maintained as a synonym to confidentiality. According to Ellenchild,<sup>17</sup> privacy is the global term that suggests protection of the physical, dispositional, and informational dimension of an individual. Confidentiality only refers to the protection of the informational—written or verbal—dimension. Because patients mostly refer to both elements as privacy,<sup>18</sup> and the terms are used interchangeable in nursing literature<sup>19</sup> and in literature concerning the bedside handover,<sup>13,20</sup> the term “privacy” will be used. Despite the difference in meaning, the impact of privacy and confidentiality on the use of bedside handovers in practice is exactly the same: they constitute an ethical hurdle to take.

## Aim

The aim of this article is to discuss and elaborate on the issue of privacy during bedside handovers from different perspectives. We built on different data sources to provide a practice-oriented answer on how to handle this issue.

## Methodology

A controlled, multicenter, and longitudinal study on feasibility, appropriateness, meaningfulness, and effectiveness of bedside briefing is currently ongoing.<sup>16</sup> The study design is based on the Medical Research Council framework for complex interventions.<sup>21</sup> Literature<sup>9,22</sup> indicated that such research was needed to provide stronger evidence on the process of bedside handover. Overall, 12 nursing wards (5 surgical, 4 medical rehabilitation, and 3 geriatric nursing wards), located in seven different hospitals in the Flemish region of Belgium were included.

A combination of research methods was used in the study and allowed to capture additional information on privacy issues from different perspectives: interviews with patients ( $n = 48$ ) interviews with nurses ( $n = 106$ ) and non-participant observations of bedside handovers ( $n = 638$ ). Next to the analysis of our own data,

a narrative review of international literature on the topic was performed to enrich the discussion and reflections on the topic.

Patients were interviewed during the development phase of the study in order to identify their preferences about the bedside handover. During the interviews, patients were actively questioned about their opinion concerning privacy. The interviews were recorded, transcribed verbatim, and analyzed thematically using the quality criteria of Lincoln and Guba,<sup>23,24</sup> including researcher ( $n = 3$ ) triangulation to enhance trustworthiness. Inductive analyses were used, meaning that themes emerged from the raw data. This approach is preferred if in-depth knowledge on a topic is lacking.<sup>23</sup>

Nurses were interviewed before the implementation of bedside handover to identify possible barriers and facilitators for using bedside handover on their ward. An interview guide was used, based on the "Contingency model"<sup>25</sup> and the "National Health Service sustainability model to healthcare improvement."<sup>26</sup> Both models assume that congruity between the demands of the innovation and characteristics of the context is necessary for successful implementation. They provide the structure, guidance, and topics to analyze the suitability of the context for implementing an innovative method,<sup>27</sup> in this case the bedside handover. Incongruities between the demands of the innovation and the necessary contextual characteristics for the method can be labeled as barriers, congruities as facilitators. A minimum of five interviews on each ward was conducted and interviews were continued until data saturation was achieved. Direct content analysis using the model of Halcomb and Davidson<sup>28</sup> was also applied, in which researchers' triangulation ( $n = 4$ ) is essential. The goal of direct content analysis is to extend and validate findings and theories from previous studies, by applying an initial coding scheme during the analyses based on the findings of these studies. Therefore, it can be referred to as a deductive approach in which the identification of new themes is still possible,<sup>29</sup> an approach that is different from the inductive method used for analyzing the patients' interviews.

A minimum of 50 individual bedside handovers on each ward ( $n = 638$  observations) was observed with a checklist to determine intervention compliance. Reasons for not conducting bedside handover were recorded. At least 20% of all observations were conducted by two researchers and Cohen's kappa was calculated ( $k = 0.85$ ). Descriptive, quantitative methods were used to analyze the observations (i.e. means, percentages, and frequencies).<sup>16</sup>

The narrative review was conducted on PubMed®, CINAHL®, and Web of Science®, mainly focusing on the following key words (or synonyms): bedside, handover or shift report, privacy or confidentiality or ethics. Moreover, a number of well-executed systematic reviews<sup>9,13,14,30</sup> were available. These systematic reviews were manually scanned for any additional publications that were missed in our search.

The study received approval from the central ethics committee of the Ghent University Hospital (B670201627044) and the local ethics committees of the participating hospitals. In each of the study phases, a written and verbal informed consent from each single participant was collected.

## Results

The study methods enabled three perspectives on privacy: the patient's perspective (interviews), the nurse's perspective (interviews), and the researcher's perspective (observations).

### *The patient's perspective*

The majority of the interviewed patients expressed a clear need for more information. Depending on their type of room (i.e. private or semi-private), patient attitude toward bedside handover differed. Patients in private rooms were more concerned with their privacy, considered bedside handovers in semi-private rooms as a possible privacy-infringing method, and indicated that such infringements were among the reasons why

they insist on having a private room and/or were willing to pay extra for it. In contrast, patients in semi-private rooms reported that they have less expectations toward privacy. They reported that their privacy is often already substantially infringed on many occasions during their admission. They indicate that information is often, mostly unaware, shared in semi-private rooms by different types of healthcare workers. For example, patients report that physicians reveal private information in the room while providing updates on the diagnoses, and that their neighboring patient becomes aware of the patient's health status by receiving wound or post-operative nursing care. In contrast to information from other health professions, information on nursing care is regarded by patients in both private and semi-private rooms as less sensitive. Especially patients in semi-private rooms are convinced that also nurses have the empathic skills to judge which information can be shared at the bedside in the proximity of their neighbor. Finally, patients report that they often spontaneously share information with their neighbor, given that they do not have personal ties to their neighbor (e.g. same community or common friends). No international in-depth research could be found in which the opinion of patients concerning privacy issues is comprehensively discussed and analyzed,<sup>13</sup> but Tobiano et al.<sup>31</sup> mention several studies on bedside handovers overall that partially relate to our findings and seem to indicate that concerns regarding privacy are more of a problem for nurses than patients or their family members.

### *The nurses' perspective*

About 60% of the nurses reported the possible infringement of privacy as an important barrier for delivering bedside handovers and used the argument to support their reluctance toward the implementation of bedside handovers. There were no differences between wards. Overall, our findings seem to correspond with the international literature which reports privacy as one of the main barriers for implementing bedside handover.<sup>9,13,14</sup>

Nurses in our study also linked privacy with uncertainties about the information that can be disclosed to patients. This uncertainty originated mostly from the fact that nurses did not know to which extent the physician already had provided information to the patient. Nurses feared to be "unprofessional." Moreover, most nurses felt uncomfortable to systematically reveal diagnoses. This indicates that the construct of privacy was interpreted in a broader sense by nurses, includes legal and hierarchical aspects and ideas about retaining professionalism, and also includes their own privacy and the protecting of themselves.

### *The researcher's perspective*

With compliance rates to the protocol of around 80%, our study demonstrated that delivering bedside handovers is not complicated. The longitudinal follow-up of these compliance rates indicates that through time, the rates do not decrease. Basic nursing activities (e.g. hand hygiene), privacy, and stimulating patient participation during the bedside handover remain points of attention. Whereas transmission of complete clinical information was hardly ever forgotten, items related to aspects of privacy and patient participation were frequently neglected: "using the call light to indicate a care process is ongoing" (21.37%), "closing the curtains and door" (8.92%), "asking visitors to leave the room" (3.94%), "asking the patient if (s)he had any further questions or something to add" (34.44%), and "introducing themselves to patients" (36.51%) were the top forgotten items on all wards. Furthermore, in 30% of the cases, the nurses decided by themselves without consulting the patient at any time not to deliver the bedside handover. Not a single patient in a semi-private room refused to undergo a bedside handover due to a possible infringement of privacy.<sup>32</sup>

In the literature, similar observations in which nurses avoided patient participation during the bedside handover could be identified.<sup>30,33,34</sup> Although these studies do not report items relating to privacy, the studies note that less than half of the patients are actually involved in the bedside handover by nurses.

## Discussion: reflection on the results

We started this discussion article with signaling that the possible breach of privacy is often reported by the nurses as the major reason not to perform a bedside handover. We continued by briefly describing our study results in order to provide different perspectives on the matter. We make four observations.

First, the interviews with patients indicate that a number of other activities than bedside handover lead to a situation in which privacy and providing information are conflicting, for example, treatment options are discussed with the patient in a semi-private room by physicians; a nurse is delivering wound care and provides information to a patient; a nurse is coaching and training a nurse student during the provision of care. This assessment shows that bedside handovers do not lead to a unique situation in which the patient's privacy could be breached by providing a patient information in a semi-private room. In the reality of practice, many privacy infringements are apparently made because of practical circumstances. As a solution for bedside handovers, they could only be introduced in single rooms. But, as not all patients can access a private room (i.e. financially or availability), this would induce an equity problem and can therefore not be regarded as a solution. As the discussion on whether or not single rooms should be standard in new hospitals<sup>35,36</sup> is a long-lasting one, it is safe to say that semi-private rooms, and so too the issue of providing information in semi-private rooms, will remain to exist. Because the patient's need for information remains and is a higher priority, a practical answer for conducting bedside handovers in semi-private rooms and dealing with the privacy issue cannot await the final decision on the future existence of semi-private rooms. It is therefore important to continue our discussion while acknowledging the importance of further discussing the desirability of semi-private rooms in hospitals.

Second, looking at the observations from our study, privacy does not seem to be as sacred as claimed by the nurses during the interviews. Although explicitly mentioned in the procedure of bedside handovers to avoid possible problems with privacy, nurses fail to "use the call light," "close the curtains and door," and "ask visitors to leave the room" on numerous occasions. Although the multitude on infringements made in other circumstances is no excuse to justify a potential breach of privacy during bedside handovers, the results from the interviews and the observations show that privacy is apparently sometimes misused in practice as an excuse to not perform bedside handover, whereas it is tolerated in other settings for reasons of practicality.

Third, based on the observations and the interviews with patients, patients seem to accept as a given fact that in certain situations a breach in privacy is difficult to be avoided. Not a single patient refused the bedside handover due to problems concerning privacy. Two possible explanations for this behavior can be given. On the one hand, it can be that patients do not mind any infringement of their privacy as long as this results in them receiving more information concerning their health. Our review of the literature made clear that, although many studies indicate that patients seem less concerned about their confidentiality than their nurses,<sup>18</sup> in-depth studies focusing on the patient's perspective concerning privacy during bedside handovers are lacking. This is remarkable, as privacy is considered so important for the implementation of bedside handover as a potential pitfall, and therefore knowledge on the patient's perspective is highly relevant.

Fourth, data from our observations seem to suggest that the nurses' point of view is paramount in deciding if, how and how much information will be provided to the patient.<sup>37</sup> In many cases, the patient was not asked if he or she preferred to receive information and whether they considered it as a breach of privacy if information was provided at the bedside. On the other hand, it cannot be excluded that patients are scared to report infringements due to a strong professional dominance of nurses.<sup>38</sup> After all, patients are dependent of their nurse as patients have limited acquaintance with the situation in general and with nurses' practices, expertise, and professional knowledge in particular. Because of this dependence, patients often choose a passive role in order to avoid being labeled as troublesome patients. Such a label could put them at

risk for receiving substandard care.<sup>39</sup> Although it cannot be excluded that this aspect has an influence on patient behavior, both explanations show a dominance of the nurses' perspective on the privacy issue.

## Discussion: reflection on the importance of “privacy”

So far, we have argued that the bedside briefing is not the only situation in care that creates an infringement of privacy and is therefore not unique. Moreover, nurses fail on numerous occasions to actively safeguard the patient's privacy and involve the patient. Next, patients in semi-private rooms seem to regard bedside handovers as acceptable. Also, the nurses' point of view on the matter seems paramount as no indications were given by patients that they found the bedside handover in semi-private rooms inappropriate. How is it possible that although there is no pressing problem with privacy in practice, patients accept the bedside handover, and bedside handovers have many advantages, privacy remains such an important barrier for nurses and many initiatives are delayed or failing?<sup>30</sup> We elaborate on two possible explanations.

First, based on the results and discussion above, we have indications that the equality of the patient's perspective is still underrepresented in professional ethics and codes that guide nursing practice.<sup>40</sup> Our professional codes still have a paternalistic character with emphasis on protecting patients and avoiding faults.<sup>40</sup> The defensive nature of these codes overlooks individual preferences of patients and restricts the courage, creativity, and critical reflection that nurses need to overcome issues with patient participation in practice.<sup>41,42</sup> The two guiding documents for nursing ethics and deontology worldwide, the International Council of Nurses' (ICN) and American Nurses Association's (ANA) code of ethics, are exemplary. With exception of the particular, well-addressed reference to informed consent and shared decision-making, there are no references in both documents to other forms of patient participation, involvement or centeredness like partnership, collaboration, and patient control. For example, none of the documents refers to the use of patient experts. Because the codes do not provide enough guidance for handling these forms of patient participation and the challenges these inflict in practice, nurses perhaps deny patients more information using the bedside handover because of their—perhaps ungrounded—fear for being labeled ethically unprofessional or their fear for legal repercussions.

Second, based on our results and discussion above, we have indications that privacy is for some nurses an excuse for not performing bedside handover in order to avoid patient participation. There are studies identifying nurses' behavior to discourage patient participation in bedside handover,<sup>13</sup> and in our interviews, nurses also expressed the will to protect their professionalism by avoiding mistakes at the bedside and being corrected by patients. Such behavior is perhaps not surprising as patient participation is not as easy as it looks, and nurses need additional skills and characteristics.<sup>43,44</sup> Person-centeredness comprises far more than just acknowledging the patient's values within a context of compassionate care. It also means providing a meaningful and authentic response to the uniqueness of patient's preferences and values.<sup>45</sup> Of course, next to avoiding patient participation, other reasons like the will to stay in control<sup>46</sup> and structural barriers<sup>47</sup> also prevent the use of bedside handovers. It is thus possible that nurses use the “privacy is more important than information” paradigm as a uniform, default, and false pretense coping strategy to deal with and avoid the complex issues that the bedside handover creates. Due to its legal foundation and repercussions, it is very difficult to force nurses to actively breach privacy. Therefore, the argument seems paramount and fits the nurses' (sub)conscious strategy to avoid bedside handover perfectly, whatever the underlying reason may be. In case of such underlying issues, it should be considered as a fallacy and false pretense. Simply accepting these excuses due to the seemingly impossible conundrum creates habits that drive nurses away from the bedside handover.<sup>10</sup>

## Discussion: implications for nursing

Throughout this discussion article, bedside handover is proposed as a method to provide the patient with necessary information for his or her effective involvement, but the implementation is hindered by the fact that it possibly endangers patient's privacy. Although bedside handover is one of many options to provide information to a patient, it is unique because it combines two processes (i.e. information provision between nurses and between nurse and patient and is consequentially very efficient). In times of economic pressure on healthcare systems and a high workload for nurses, an intervention like bedside handover is a preferable opportunity, taking into account its positive effects on patient participation by sharing nurses' knowledge and power and receiving patient's feedback.<sup>3</sup> It is therefore important to explore the possible solutions to overcome the issue of privacy during the bedside handover. To do this, we start from two different and mutually exclusive possibilities: there is a problem with privacy during bedside handover, and there is no problem with privacy during the bedside handover. In reality, both are possible and applicable, depending on the situation.

If there is an actual conflict between privacy and providing information in a semi-private room, this is not unique and should therefore not be the reason to terminate the use of bedside handovers. After all, this would mean that both patients and nurses are denied the possibility of receiving or providing better and more qualitative care. Instead, solutions should be sought to preserve the patient's privacy as much as possible. In contrast with most other situations where information is shared, the bedside handover is a conscious choice of sharing information in a possibly privacy infringing situation. The consciousness of the process enables the provision of active steps and measures to protect the patient. First, informed consent can be obtained from both patients in the room in order to inform patients about what is going to happen and receive explicit consent. The patient's consent for family presence during the bedside handover should be an explicit part of this. Second, actions and tactics to prevent the spreading of sensitive information should be strictly followed: closing the door and curtains, asking visitors to leave, discussing sensitive information elsewhere, using notes or pointing at information, using a muted voice in proximity of the patient, and agreements with the physician. Third, nurses can be trained or should have the professional expertise and sensitivity to identify and avoid mentioning sensitive information.<sup>13,30,34</sup>

If there is no actual conflict between privacy and information, nurses use privacy to avoid bedside handovers for various reasons. For us, these various reasons are all indications that we should critically look at our guiding frameworks, codes of conduct, and ethical guidelines in order to fix the issues with bedside handover and by extension other patient participation initiatives that may challenge nursing staff in their daily behavior. After all, patient participation is an important factor to facilitate patient-centeredness and patient empowerment, both key concepts for the future of healthcare.<sup>4</sup> It seems that during the current nursing profession's search for and emphasis on self-realization and professional identity, which emphasizes the nurse-oriented idea instead of the patient-oriented idea,<sup>48</sup> we have forgotten about the essence of our professional existence: the patient.<sup>8</sup> If we are sincere about our intention to make patient involvement truly happen in practice, education, and research, it would therefore be a paradox for us not to explore how we can make our guiding frameworks patient-centered. In the spirit of true patient participation, we claim that patients should be involved in this process. Taking into account the fast evolutions and disruptive changes in healthcare, it is impossible to answer such questions only among the nursing community. One could claim that patient involvement threatens our unique professional identity, but we refute this point of view. In fact, we are convinced that by sharing the power with our patients on these critical issues, we truly live up to our historical legacy and obligation to be the patient's advocate.<sup>49</sup> The issues concerning the guiding framework described above are possibly also applicable to other healthcare professions, but in our opinion, nurses should take the lead in this discussion for two reasons. Nurses have the historical legacy and

obligation to be the patient's advocate<sup>49</sup> and the nursing profession regards itself as crucial for promoting patient participation.<sup>50</sup>

## Conclusion

Our reflections should be considered as eye-openers and an indication that there is an urgent need for further exploration and clarification. By reflecting on and discussing the privacy issue in bedside handover from different perspectives, we have discussed whether or not privacy is a reason to cease the use of bedside handovers. Overall, we see no reasons not to perform the bedside handover. If bedside handover does breach privacy, we argue that potential privacy-related issues should not be a reason to obstruct or stop the further implementation of bedside handovers in nursing practice. In our opinion, the use of bedside handovers does not inflict issues with privacy of such gravity and uniqueness that the method cannot be used safely in practice, as long as steps are taken to safeguard the patient's privacy as much as possible. In cases where it does not infringe privacy, any arguments claiming otherwise are perhaps used under the false pretense to cover up other reasons to not perform the bedside handover. In order to address the latter, nursing guiding frameworks should be subject to revision. As the nursing profession is moving in the 21st century, the emphasis on the individual patients' perspectives in daily practice will only cause new questions to arise, challenging the sustainability and validity of our current guiding frameworks. Patients should be involved in defining our moral compass and ethical guidelines. By sharing such power with patients on these critical issues, nurses truly live up to the historical legacy and obligation to be the patient's advocate.

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