LETTER TO EDITOR OPEN ACCESS

# The 24-Hour Nursing Ward Report: Concern and Way Forward

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Dear Editor,

Effective and consistent nursing communication is critical for managing the hospital ward situation and patients' situations. In the Brunei healthcare setting, one way to achieve this is by completing 24-hour nursing ward reports (henceforth refer to the reports), which were first introduced in the 1980s. The reports collect relevant information on patient admissions, discharges, intra-hospital transfer, bed availability, daily census, and admission needs. The reports begin with a written description by an assigned nurse at the end of each shift and continue with a verbal handover to the nursing officer on-call of the shift. The officer then verbally reports to the head of nursing administration or the hospital's matron.

The communication through the reports is critical because the hospital's matron needs to be cognisant of the present state of each ward and the daily bed occupancy rate. Additionally, the report must contain accurate and up-to-date information about the patient's treatment and significant changes over the 24 hours (1). A detailed analysis of the reports also helps the hospital's matron coordinate patients and beds being assigned to the appropriate hospital ward, which is salient in promoting optimum utilisation of hospital beds. Therefore, the reports help promote high standards of nursing care by highlighting issues surrounding daily census, but they also enhance patient safety and minimise healthcare risks. These components significantly influence the continuity of care and patient safety (2, 3).

Despite its merits, there have been concerns about how the reports are documented and handed over. Our preliminary qualitative findings examine hospital nurses' and nursing officers' experiences preparing the reports (4). The first concern highlighted that the reports are only as good as the nurses' and nurse officers' understanding of the report. Generally, nurses considered that the reports should document what nurses actually do for patients, such as clinical assessment. However, they felt they were given inadequate guidance regarding what to report.

This is followed by the second concern surrounding documentation and reporting practices. Poor documentation and incompetent reporting can potentially affect effective communication in the coordination and continuity of nursing care. For example, incomplete tasks, priority care or changes in the patient's condition must be systematically documented and reported via a structured handover process. Without these details, patient safety may very well be compromised. This concern is related to the third point mentioned in the preliminary finding, whereby there appears to be a discrepancy between the extensive verbal handover and the brief written report provided by the nurses. Previous studies have highlighted the benefits of adopting a brief and written summary of patients to augment verbal handover (5-7).

The fourth concern is about the report's lack of 'nursingness'. In most cases, the written report and verbal handover seem to weigh medical information more than nursing information significantly. For example, information on the type of blood test taken and changes in treatment prescribed was reported in greater depth. However, little was said about patients'

daily living activities and nursing care. This point poses a profound subsequent concern for the nursing profession: the lack of standardised information within the 24-hour reports. It is considered fundamental that such reports would include identifying the patient, clinical history, clinical status, treatment plan and outcomes of care, clinical risks, or alerts, and a planned date for discharge should all be included (6). Indeed, patient safety depends on consistent and accurate information during handover (8). Therefore, this critical aspect must be competently reported to minimise confusion between nurses and nurse managers and prevent missing patient information (1). While it is plausible that documenting and handing over the report might be arduous, it is fundamental for both nurses and nurse managers to understand its impact on patient safety, patient satisfaction, continuity of care, and other clinical outcomes (9, 10).

In short, the preliminary findings of our study suggest that the reports are regarded as being instrumental in the context of maintaining clinical and patient care standards. While there is much to be done before this can be significantly achieved, the current process of writing and handing over the report has potential for careful consideration in the top management, principally in augmenting the understanding of the reports and the practices of its documentation, and the handover process. It is also crucial that nursing continue to focus on greater professional accountability throughout the use of the report (11). This core responsibility emerged from the premise that nurses and nursing officers would carry out their duties competently and safely without jeopardising the safety of patients. We hope this laudable aspiration allows open communication between the nurses involved and nursing officers and brings better insight into tangible approaches to maintain a high standard and quality of 24-hour reports.

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