Nursing bedside clinical handover - an integrated review of issues and tools

Aims and objectives: This article reviews the available literature that supports implementing bedside clinical handover in nursing clinical practice and then seeks to identify key issues if any. Background: Clinical handover practices are recognised as being an essential component in the effective transfer of clinical care between health practitioners. It is recognised that the point where a patient is 'handed over' from one clinician to another is significant in maintaining continuity of care a ...

Author(s): Anderson, J.K. ; Malone, L.M. ; Manning, J.J. ; Shanahan, K.

Title: Nursing bedside clinical handover - an integrated review of issues and tools

Journal: Journal of Clinical Nursing

ISSN: 1365-2702

Volume: 24

Year: 2015

Pages: 662 - 671

Abstract: Aims and objectives: This article reviews the available literature that supports implementing bedside clinical handover in nursing clinical practice and then seeks to identify key issues if any. Background: Clinical handover practices are recognised as being an essential component in the effective transfer of clinical care between health practitioners. It is recognised that the point where a patient is 'handed over' from one clinician to another is significant in maintaining continuity of care a ...

URLs:

**FT:** http://dx.doi.org/10.1111/jocn.12706

**PL:** http://primo.unilinc.edu.au/primo_library/libweb/action/dlDisplay.do?vid=CSU2&docId=dtl_csu63911
Nursing Bedside Clinical Handover – An integrated review of issues and tools

ABSTRACT

**Aim:** This article reviews the available literature that supports implementing bedside clinical handover in nursing clinical practice and then seeks to identify key issues if any.

**Background:** Clinical handover practices are recognised as being an essential component in the effective transfer of clinical care between health practitioners. It is recognised that the point where a patient is ‘handed over’ from one clinician to another is significant in maintaining continuity of care and that doing this poorly can have significant safety issues for the patient.

**Design:** An integrated literature review.

**Method:** A literature review of 45 articles was undertaken to understand bedside clinical handover and the issues related to the implementation of this process.

**Results:** It was identified that there are a number of clinical handover mnemonics available that provide structure to the process and that areas such as confidentiality, inclusion of the patient/carer and involving the multidisciplinary team remain topical issues for practitioners in implementing good clinical handover practices.

**Conclusions:** This literature review identified a lack of literature available about the transfer of responsibility and accountability during clinical handover. The literature identified that nurses were more concerned about confidentiality issues than were patients. The use of a structured tool was strongly supported by much of the literature reviewed; however no one singular tool was considered suitable for all clinical areas. There was little in the literature which described auditing practices of clinical handover which is an area requiring further research.
**Relevance to Clinical Practice:** Nursing clinicians seeking to implement best practice within their professional speciality should consider some of the issues raised within this article and seek to address these issues by developing strategies to overcome them.

**Keywords:** clinical handover, auditing, patient safety, communication tool, nursing, confidentiality

**Summary box** - What does this paper contribute to the wider global clinical community?
- A comparison of available research findings in relation to nursing clinical handover
- Identifies areas of further investigation

**INTRODUCTION**

Clinical handover practices are recognised as being an essential component in the effective transfer of clinical care between health practitioners. It is recognised that the point where a patient is ‘handed over’ from one clinician to another is significant in maintaining continuity of care and that doing this poorly can have significant safety issues for the patient (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2012).

**AIM**

There is a substantial amount of literature available on the efficacy of clinical handover yet current practice still demonstrates that clinical handover is an area of poor performance. This article reviews the available literature that supports implementing bedside clinical handover in nursing clinical practice and then seeks to identify key issues if any which contribute to the poor implementation of bedside clinical handover.

**METHOD**
An integrative review of the literature was undertaken to summarise past literature and provide a comprehensive understanding of the context of nursing bedside clinical handover (Whittemore & Knafl, 2005). A database search of EBSCOhost Health (including CINAHL, Academic Search Complete, Primo Search, Google Scholar) was undertaken. The search terms: clinical, handover, bedside and nursing were used in the database searches. This search strategy yielded a total of 61 published articles. Duplicates of articles which were identified through the search of the database were removed after an initial screening of titles and abstracts. The full text articles were then assessed for eligibility. Inclusion criteria were that the article described research related to clinical handover involving nurses and midwives and published between 2003 and 2013. This search identified 45 articles for inclusion in the review. These articles were then examined to identify significant source articles pre-dating this time period which potentially may have been useful to further inform our search. A total of 25 articles that met the criteria were then further interrogated to identify major issues.

RESULTS

In conducting the review, a range of tools in the form of mnemonics to assist in the delivery of handover as well as various issues were identified in relation to the delivery of bedside clinical handover. Critical comment for each issue is provided. Table 1 provides a concise summary of the results of the literature review.

After conducting the literature review the following issues were identified for further consideration. These issues included: transfer of responsibility and accountability of care; confidentiality; bedside handover; patient/carer involvement; multi-disciplinary approach; structure and tools; and auditing clinical handover practices.

**Transfer of responsibility and accountability of care**

The concept of transferring the responsibility and accountability for clinical care during handover is an important area to be addressed. A widely accepted definition of clinical handover is:
“the transfer of responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on temporary or permanent basis”

(Australian Medical Association, 2006, cited in Australian Commission on Safety and Quality in Health Care [ACSQHC], 2012)

Chin, Warren, Kornman and Cameron (2012) explored staff perceptions of when the transfer of responsibility and accountability actually occurred in their study of maternity clinicians. Whilst conducting a number of interviews and focus groups, they found that most participants did not instinctively make the connection between the transfer of responsibility and accountability as a primary function of the handover process. It was only when asked specifically about this function that the connection was made.

Chin, et al., (2012) found differing perceptions about when ‘complete transfer’ of responsibility and accountability actually occurred with some staff reporting it was distinguished by the end of the handover communication, others thought it was marked by rostered time off duty, and others at the actual commencement of work. Of note was the personal responsibility and accountability which midwives felt was ongoing even when they had handed over to staff coming on to the following shift. In some cases this was due to both personal and professional attachment to the wellbeing of the patient and their care.

Within the literature there was recognition that many clinicians felt that transfer of responsibility and accountability occurred at end of shift rather than at handover. Despite the significance of this issue, limited literature was located which described the transfer of responsibility and accountability at handover.

Confidentiality

Only eight out of the 41 articles reviewed raised the issue of confidentiality or discussed this aspect of clinical handover (Chaboyer, McMurray, & Wallis, 2010; McMurray, Chaboyer, Wallis, Johnson, &
Concerns about confidentiality included patient and nurse perceptions and legal implications in relation to privacy. Greaves (1999) reported that confidentiality in relation to bedside handover was a concern for some of the patients interviewed. This is contradicted by a later study by McMurray (2011), where patients were less concerned than nurses about confidentiality issues. Nurses also expressed anxiety in relation to patient confidentiality, being particularly concerned about maintaining confidentiality in public and that this acts as a barrier to effective communication (Wilson, 2011). The implications for nurses in relation to their legal obligations are a significant factor when implementing bedside clinical handover in practice. In response to these concerns, Chaboyer, et al., (2010) found that nurses discussed information they thought was sensitive in places other than the bedside.

**Bedside Handovers**

The concept of handover at the patient’s bedside is not a new idea (Greaves, 1999), but implementation has been variable (Chaboyer et al., 2010; McMurray et al., 2011) and some authors question the quality of research which supports its implementation (Staggers & Blaz, 2013). In the survey of 259 nurses completed by Street et al., (2011) the authors found great variability in duration, location and method of handover, however they indicated that patient involvement was improved with bedside handovers.

Anderson and Mangino (2006) indicated that a financial benefit was found as overtime decreased, which they attributed to bedside handover being less time consuming than a recorded handover. However, in their survey of 23 staff members Wilson (2011) found that an estimation of time taken was variable as some staff found it to be shorter and others longer than it had been before it was moved to the bedside (although they did also introduce a structured process at the same time). In contrast in an older study O’Connell and Penney (2001) reported increased interruptions which lengthened the time taken for handover.
Anderson and Mangino (2006) found staff members were better able to prioritise their patient care as they had sighted patients early in their shift. Anderson and Mangino (2006) also reported an increase in physician satisfaction as nurses were better informed about the patients they were caring for. In fact, McMurray et al. (2011) and Chaboyer et al. (2010) concluded that the bedside handover provided a greater patient-centred care and focus. However, other authors describe fears about confidentiality, privacy and causing some distress to patients as inhibiting their desire to implement bedside handover (Fenton, 2006; B. O’Connell, Macdonald, & Kelly, 2008). Johnson, Jeffries and Nicholls., (2012) indicate that the introduction of bedside clinical handover should be accompanied by comprehensive education in communication. However, Chaboyer et al (Chaboyer et al., 2009) and McMurray et al (McMurray, Chaboyer, Wallis, & Fetherston, 2010) 2010 in separate studies agree that bedside handovers should not be seen as an isolated initiative but as a whole strategy of transforming nursing and patient centred care.

**Patient/Carer Involvement**

The degree to which patients are currently involved in handover processes is debatable. In their study of 81 patient handovers, which occurred in seven different clinical settings, Johnson, et al., (2012) only 5% involved the patient and this was usually a very superficial involvement of greeting only. In a study about the perceptions of maternity patients in relation to handover, Chin, et al., (2011) found that approximately 50% of patients had been involved in handover. Similarly Chaboyer et al., (2010) in their observation of 500 bedside handovers found that patients actively participated in less than half. McMurray, et al., (2011), indicate that involving the patient in handover is an important aspect of patient-centred care and encourages their active involvement in decision making.

Involving patients in a handover process has the benefit of providing them with information with some patients feeling reassured when able to participate in ‘shared decision making’ (Chin et al., 2011; Greaves, 1999; Johnson et al., 2012; McMurray et al., 2011; Wildner & Ferri, 2012; Wilson, 2011), and
allows them to verify what is said (McMurray et al., 2011). In a study of patient perception of handover, Chin, et al., (2011) found that patients felt they often had more information than clinicians and their presence in handover allowed them to clarify, add, validate and update this information. When they introduced bedside handover, Anderson and Mangino (2006) felt that patient involvement was improved as demonstrated through their measurement of increased patient satisfaction. These findings were confirmed in a study by Wildner and Ferri (2012) which compared three different types of handover practice. Tobiano, Chaboyer and McMurray (2013) discuss the perceptions of family members in bedside handover and indicate that it improves patient centred care, but little other literature mentions the involvement of family members in the practice of bedside handover.

Not all patients felt that their involvement was positive. A small number of patients felt that their presence may have had a negative effect on handover, with some indicating that it was important for clinicians to avoid jargon and being patronising during handover (Chin et al., 2011). An older qualitative study indicated that being included in a tokenistic way was preferable to patients who had been reduced to overhearing or ‘eavesdropping’ on their handover previously (Greaves, 1999). Greaves (1999) also found that patients preferred to be more passive in their handover, whereas McMurray et al., (2011) found that not all patients wanted the same level of interaction although they valued the process of bedside handovers. There is a need to clarify the role of the patient in the handover process and to develop methods to actively involve the patient in the handover process, although no indication was given on how this should occur.

**Structure and Tools**

There are numerous methods of adopting a structured approach to clinical handover. Klim et al., (2013) describe key elements and essential information in clinical handover which they feel can be addressed with a structured handover framework. A number of different tools have been implemented in various settings in an attempt to adopt a standardised approach to clinical handover (Bost, Crilly, Patterson, &
examples include ISBAR (introduction, situation, background, assessment and recommendation) and P-VITAL (presenting information, vital signs, input and output, treatments, admission or discharge criteria and legal documents).

Wilson (2011) reported that the introduction of the use of the P-VITAL tool in a hospital emergency department reduced errors through early identification of problems, is sustainable and cost-effective and offers opportunities for teaching and learning. Chin et al., (2011) describe the use of cognitive artefacts (cardiotocograph, antenatal records and birth plans), in a maternity unit setting, to prompt memory and as a way of cross-checking the information they have collected for accuracy, detail and to fill in gaps of missing information.

Seifert (2012) cite a number of tools in the American Operating Room Nurses (AORN) ‘recommended practices for transfer of patient care information’ and lists the SBAR format, I PASS the BATON (introduction, patient, assessment, situation, safety concerns (the) background, actions, timing, ownership, next), SURPASS (SURgical PAatient Safety System), and SHARED (situation, history, assessment, request, evaluate, document). TeamSTEPPS training in clinical handover is reported in the literature by Thomas, Schultz, Hannaford and Runciman (2012) and Göbel et al., (2012) as a tool, used in some acute care settings, adapted from Formula 1 pit-stop models which are designed to increase standardisation and efficiency of communication during handover. Fenton (2006) describes the UK National Health System (NHS) Essence of Care handover guide which includes, as a minimum data set: continence; pressure areas; safety; self-care; hygiene and oral care; privacy and dignity; communication; nutrition; and hydration as these are considered key aspects of patient care. This guide also covers the usual information e.g. name, age, diagnosis etc.

The use of these tools to reduce errors of omission and enhance the reliability of information transfer by decreasing the reliance on memory and maintaining a focus on important aspects of care are an emerging theme in the literature identified by several authors (Clarke & Persaud, 2011; Johnson et al.,...
The Garling report (2008) included a recommendation that hospital policy mandates shift handover with a structured tool, at least part of which should be conducted at the bedside. Staggers and Bolz (Staggers & Blaz, 2013) acknowledge that studies about handover functions and rituals are readily available however the need to have tailored structure of the handover needs to be contextualised to fit the clinical area and the need of the staff member for adequate information.

**Auditing Clinical Handover Practices**

Measuring the effectiveness of handover practice can provide the clinician with an understanding of where potential areas for improvement in the clinical handover may exist (Jeffcott, Evans, Cameron, Chin, & Ibrahim, 2009). A range of measurement studies were found within the literature which included clinicians responding to questionnaires (Ahmed, Mehmood, Rehman, Ilyas, & Khan, 2012), semi structured interviews together with observational studies of the handover practice (Bomba & Prakash, 2005; Fenton, 2006; Jefferies, Johnson, & Nicholls, 2012). Studies found in the literature where clinical handover had undergone an evaluation method ranged from questionnaires (which are reliant on the respondent providing open and honest response regarding their own practice) to action research studies where observational behaviour was viewed then critiqued, this is open to the observers interpretation of the event (Bomba & Prakash, 2005; Ellul & Robson, 2011; Johnson et al., 2012).

The reviewed literature provided no guidance as to an acceptable tool for use in auditing the practice of clinical handover. Clarke & Presaud (Clarke & Persaud, 2011) identify that there are gaps in the knowledge regarding the process and function of handover and that within these gaps, areas for improvement of the handover process may occur. Further research in developing an audit tool for the evaluation of clinical handover practices is an area that is required.

**DISCUSSION**
This article has considered the literature related to bedside clinical handover and identified several themes which impact on the implementation of this process. The transfer of responsibility and accountability was felt by clinicians to occur at the end of their shift rather than at handover. This is significant in situations where there is a substantial overlap in hours of duty where accountability for patient care is not clear. This creates a potential for error in the form of duplication or omission of care being provided during this period of time.

Nurses continue to express anxiety in relation to patient confidentiality; being particularly concerned about maintaining confidentiality in the public space of the bedside when other patients are nearby. This contributes to poor communication between staff and the exclusion of the patient in participating in decision making about their care. This concern has its roots in the nurses’ legal obligations regarding patient privacy and confidentiality. This is commonly resolved by discussing sensitive information in a private area away from the bedside, but leads to habits that continue to discourage bedside clinical handover. There is some suggestion that further education about effective communication in bedside clinical handover should be part of an integrated communication strategy, rather than being seen as an isolated process in the delivery of patient centred care.

It was commonly acknowledged in the literature that a single handover tool did not suit all clinical areas; however, customising a handover tool which included core and essential information was well supported. Consequently evaluating the effectiveness of a handover tool or the handover process is an area which requires further investigation. This is particularly relevant as further changes are implemented which seek to improve this process overall.

**CONCLUSION**

This literature review identified a lack of literature available about the transfer of responsibility and accountability during clinical handover. A limited number of articles mentioned a lack of clinician recognition of the significance of this issue and clear acknowledgement of when this occurs. Literature
identified that nurses were more concerned about confidentiality issues than were patients, despite
general benefits of improved communication and involvement of patients and carers being identified in
the conduction of bedside clinical handover. Multidisciplinary approaches were recommended by a few
authors but research indicated that it was poorly implemented. The use of a structured tool was strongly
supported by much of the literature reviewed; however no one singular tool was considered suitable for
all clinical areas. There was little in the literature which described auditing practices of clinical handover
which is an area requiring further research.

RELEVANCE TO CLINICAL PRACTICE

Nursing clinicians seeking to implement best practice within their professional speciality should consider
some of the issues raised within this article and seek to address these issues by developing strategies to
overcome them.
REFERENCES


<table>
<thead>
<tr>
<th>Source</th>
<th>Aim</th>
<th>Method</th>
<th>Major findings</th>
</tr>
</thead>
</table>
| Staggers & Blaz, 2013         | To make recommendations for change processes involving the computerisation of handovers on medical and surgical units. | Integrative literature review from peer reviewed journals               | 1. Verbal handovers have important functions other than information transfer and need to be retained  
2. Handover should be tailored to meet the contextual needs of nurses. Further research is required.  
3. A preference for bedside handovers was not supported. |
| Ahmed, Mehmood, Rehman, Ilyas, & Khan, 2012 | To investigate the ability to improve compliance and quality of clinical handover through a standardised and structured template. | Pre and post survey related to an education session introducing a computerised template. | 1. Recommended a structured & standardised handover tool  
2. Audit of handover practice demonstrated improvement after training had occurred |
| Bost, Crilly, Patterson, & Chaboyer, 2012 | To explore clinical handover between ambulance and ED staff and identification of strategies that improves information transfer. | An ethnographic approach which included participant observation; conversational interviews; examination of handover tools. | 1. Quality of handover related to personnel expectations; prior experience; workload; working relationships.  
2. Issues included: lack of active listening; access to written information. |
| Chin, Warren, Kornman, & Cameron, 2012 | To report on perceptions of transfer of responsibility and accountability. | A qualitative study of semi-structured interviews and focus groups. The constant comparative method was used, allowing the emergent of multiple themes | 1. Responsibility & accountability were not the primary focus of these clinicians, rather the focus was the transfer of information. |
| Jefferies, Johnson, & Nicholls, 2012 | To identify differences between patient information in nursing documentation and handover. | Content and textual analyses were undertaken, including 67 items of nursing documentation and 195 transcripts of clinical handover. | 1. Information discussed in clinical handover was not reflected in nursing documentation.  
Handover produced a more complete picture of patient conditions. Documentation was |
<table>
<thead>
<tr>
<th>Source</th>
<th>Aim</th>
<th>Method</th>
<th>Major findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Johnson, Jefferies, &amp; Nicholls, 2012</td>
<td>To develop a tool that ensures inadequate information transfer does not compromise patient safety.</td>
<td>Reviewed structured handover tools (SBAR, ICCCO, PVITAL, MIST &amp; NUTS) and its content and organization during 81 handovers.</td>
<td>1. Recommends: identification of the patient and clinical risks, clinical history/presentation, clinical status, care plan and outcomes/goals of care (ICCCO).</td>
</tr>
<tr>
<td>Thomas, J. Schultz, Hannaford, &amp; Runciman, 2012</td>
<td>To identify an appropriate design for clinical handover based on incidents identifying critical issues.</td>
<td>Identified critical issues in 459 incidents related to handover.</td>
<td>1. Recommends a structured approach to handover using standardized sets of information.</td>
</tr>
<tr>
<td>Wildner &amp; Ferri, 2012</td>
<td>To compare bedside clinical handover model to the traditional model.</td>
<td>Using Lewin’s change theory/model 2 questionnaires, one to staff and one to patients and carers were analysed, interviews with staff were then conducted post questionnaire and a focus group held with staff to further interrogate data.</td>
<td>1. Both quantitative and qualitative results highlighted advantages for staff in implementing bedside handover as increased trust, better communication with patients and better identification of problems, for patients increased safety, opportunity to be involved with care decisions 2. Overall recommended that bedside handover was the preferred model.</td>
</tr>
<tr>
<td>Chin, Warren, Kornman, &amp; Cameron, 2011</td>
<td>To report patients’ perceptions of handover in quality and safety.</td>
<td>A mixed-method study including qualitative semi structured interviews (qualitative) and medical record analysis (quantitative).</td>
<td>1. Most patients are aware of handover. 2. Patients perceive handover is effective when, clinicians are aware of information, and felt it represented positive aspects of</td>
</tr>
<tr>
<td>Source</td>
<td>Aim</td>
<td>Method</td>
<td>Major findings</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Clarke &amp; Persaud, 2011</td>
<td>To identify strategies to improve safety and effectiveness of clinical handovers.</td>
<td>A 4-stage change model was implemented.</td>
<td>1. Continued evaluation is required to build understanding and ensure improved practice.</td>
</tr>
<tr>
<td>McMurray, Chaboyer, Wallis, Johnson, &amp; Gehrke, 2011</td>
<td>To examine patients’ perspectives of bedside handover.</td>
<td>A descriptive case study involved 10 patients.</td>
<td>1. Patients appreciated being involved in their care.</td>
</tr>
<tr>
<td>Street, Eustace, Livingston, Craike, Kent &amp; Patterson, 2011</td>
<td>To implement a bedside handover process.</td>
<td>Cross-sectional survey of 18 wards in 1 hospital for current views of handover, auditing of new bedside handover process measured introducing new staff at handover to the patient, including the patient in handover and use of the SBAR tool</td>
<td>1. Although bedside handover was conducted, the patient was not commonly involved.</td>
</tr>
<tr>
<td>Wilson, 2011</td>
<td>To establish and implement a P-VITAL handover process.</td>
<td>Compared pre and post implementation of PVITAL</td>
<td>1. Recommends a structured handover tool 2. Highlights importance of bedside handover</td>
</tr>
<tr>
<td>Source</td>
<td>Aim</td>
<td>Method</td>
<td>Major findings</td>
</tr>
<tr>
<td>--------</td>
<td>-----</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>Chaboyer, McMurray, &amp; Wallis, 2010</td>
<td>A descriptive study of bedside handover.</td>
<td>A case study two hospitals and including six wards was undertaken. This study used observation of practice and interview with staff</td>
<td>1. Structural elements which were considered important included: staff, patients, handover sheet and bedside chart. 2. Described standard operating protocols for the implementation of bedside handover but caution that benefits of bedside handover are still unclear.</td>
</tr>
<tr>
<td>Evans, Murray, Patrick, Fitzgerald, Smith, Andrianopoulos, Cameron, 2010</td>
<td>To evaluate handover between scene of incident to a Trauma Centre.</td>
<td>Purposive samples of 25 trauma patients brought in by ambulance were randomly selected. Comparisons were made between pre-hospital, in-hospital handover and written documentation.</td>
<td>1. Recommends the use of a formal handover structure/template to reduce information loss.</td>
</tr>
<tr>
<td>Evans, Murray, Patrick, Fitzgerald, Smith, &amp; Cameron, 2010</td>
<td>To develop a standard handover tool; identify factors contributing to effectiveness; determine feasibility of data transmission prior to patient arrival; &amp; identify effective methods to display data in trauma.</td>
<td>A grounded theory study involved paramedics and trauma staff.</td>
<td>1. Recommends adoption and evaluation of a standardised handover to reduce information loss.</td>
</tr>
<tr>
<td>McMurray, Chaboyer, Wallis, &amp; Fetherston, 2010</td>
<td>To identify change factors in 2 hospitals during the implementation of bedside handover.</td>
<td>Semi-structured observations and in-depth interviews were conducted with a purposive sample of nurses.</td>
<td>1. Successful change needs to be supported by a quality improvement strategy.</td>
</tr>
<tr>
<td>Chaboyer, McMurray, Johnson, Hardy, Wallis &amp; Ying, 2009</td>
<td>To improve patient-centred care through implementation of bedside handover in nursing.</td>
<td>A quality improvement activity involving staff feedback through surveys.</td>
<td>1. In order to successfully implement bedside clinical handover there needs to be support from both staff and managers and it</td>
</tr>
<tr>
<td>Source</td>
<td>Aim</td>
<td>Method</td>
<td>Major findings</td>
</tr>
<tr>
<td>--------</td>
<td>-----</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>Jeffcott, Evans, Cameron, Chin, &amp; Ibrahim, 2009</td>
<td>To introduce a conceptual framework for a research agenda linked to patient safety.</td>
<td>A comparative study where five relevant frameworks were identified in consultation with clinicians, researchers and policy makers.</td>
<td>1. Identified a knowledge gap between poor handover leading to patient harm &amp; discontinuity in care; discussed accountability &amp; responsibility &amp; need for clarity. 2. Further research was recommended.</td>
</tr>
<tr>
<td>O'Connell, Macdonald, &amp; Kelly, 2008</td>
<td>To describe nurses’ perceptions of handover and to identify its strengths and limitations.</td>
<td>Nurses responded to a staff survey.</td>
<td>1. Conflicting opinions about effectiveness of handover process were revealed. A number of nurses were positive about patient information and the opportunity to clarify patient care possible improvements were also identified.</td>
</tr>
<tr>
<td>Wong, Yee, &amp; Turner, 2008</td>
<td>To Identify gap in literature about legal issues and patient role regarding handover.</td>
<td>Literature review of 218 articles.</td>
<td>1. Major themes identified risks during: handover risks; use of abbreviations; and patient characteristics affecting handover.</td>
</tr>
<tr>
<td>Benson, Rippin-Sisler, Jabusch, &amp; Keast, 2007</td>
<td>To describe current handover processes.</td>
<td>Analysis of written surveys &amp; discussion forums.</td>
<td>1. Improved handovers require education of staff and quality assurance input to monitor ongoing effectiveness.</td>
</tr>
<tr>
<td>Anderson &amp; Mangino, 2006</td>
<td>To improve patient involvement in handover by introducing bedside handover.</td>
<td>Quality improvement activity related to results after introduction of bedside handover in a single unit.</td>
<td>1. Improved patient satisfaction; patients felt safer; decreased time required for handover, leading to cost efficiencies, improved staff relationships 2. Recommended structured handover.</td>
</tr>
<tr>
<td>Source</td>
<td>Aim</td>
<td>Method</td>
<td>Major findings</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Fenton, 2006</td>
<td>To assess impact of structured handover guide.</td>
<td>Pre &amp; post implementation audit conducted for 15 patients randomly selected at 5 handovers over 4 week period. This audit was repeated 6mths later; improvement was demonstrated.</td>
<td>1. Staff were positive about using guide.</td>
</tr>
</tbody>
</table>