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Nurse Handover: Patient and staff experiences

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ABSTRACT

Aim and objectives

To understand the purpose, impact and experience of nurse handover from patient and staff perspectives.

Background

Poor communication is increasingly recognised as a major factor in healthcare errors. Handover is a key risk point. Little consensus exists regarding the practice in nursing but the trend is towards bedside handover. Research on patient and staff experiences of handover is limited.

Design

A qualitative and observational study on two acute wards in a large urban hospital in the UK.

Methods

We conducted interviews with patients and staff and observed handovers, ward rounds and patient staff interactions.

Results

We found diverse forms of nurse handover, used in combination: office based (whole nursing team), Nurse in Charge (NIC) to NIC, and bedside. Patients and nurses views concurred on the purpose of bedside handover: transference of information about the patient between two nurses, and about the medical ward round which was seen as a discussion with the patient. Views diverged regarding the purpose and value of office handover. . Bedside handover differed in style, content, and place of delivery, often driven by concerns regarding confidentiality and talking over patients and there were varied views on the benefits of patient involvement in bedside handover. Nurses worked beyond their shift end to complete handover. Communication problems within the clinical team were identified by staff and patients.

Conclusions

Whilst it is important to agree the purpose of handover and develop appropriate structure, content and style it need not be a uniform process in all clinical areas. Nurse training to deliver bedside handover and patient information on the purpose of handover and the patient's role would be beneficial.

Relevance to clinical practice

The findings will be used to inform the future development of nurse handover and guide patient involvement as part of the Trust's strategic aim to improve communication.

KEY WORDS:

Nurse handover, patient experience, patient involvement, bedside handover, ward round, communication, nurse-patient relationship

INTRODUCTION

Communication, particularly between patients and clinicians, has been identified as a key tenet underpinning 'patient-centred care', which is 'determined by the quality of interactions between patients and clinicians', and 'encapsulates healing relationships grounded in strong communication and trust' (Epstein et al. 2010).

It is increasingly recognised that poor communication is a major factor in healthcare errors, with handover a major risk point leading to poor patient experience and impacting on both patient safety and clinical outcomes (Neale et al. 2001) (Australian Commission on Safety & Quality in Health Care [ACSQHC], 2012) (British Medical Association Junior Doctors Committee 2004).

BACKGROUND

Clinical handover is a routine communication event occurring across a range of clinical settings and has been defined for doctors as:

"...the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis" (British Medical Association Junior Doctors Committee 2004).

This definition seems to apply equally well to nursing handover which is central to nurse communication (National Nursing Research Unit 2012). It is recognised as a complex and dynamic interaction (Kerr 2002) and yet there remains little consensus regarding its primary function, its location and structure (Street 2011, Anderson 2006, Gage 2013). In the UK and internationally there is a move towards nurse handover at the bedside as part of the patient-centred care agenda; however, there is some evidence that suggests patients may still not be involved in the process (National Nursing Research Unit 2012, Gage 2013).

There are few studies that describe the experience of handover from the patient perspective (Lu et al 2014). Cahill (1998) discusses the patients' lack of confidence and clarity of their role in handover as being a barrier to involvement whilst Greaves (1999) highlights that patients saw bedside handover as enhancing communication about their condition. Involving patients in handover is appreciated and valued by some patients and perceived as enhancing individual care (McMurray et al 2010, Kerr 2013, Maxson 2012, Bradley and Mott, 2013) but nurses seem to have greater concerns regarding confidentiality during bedside handover than patients which can lead to 'bedside' handover happening elsewhere, excluding patients from decision making about their care. (Anderson 2014, Kerr 2013). Johnson and Cowin (2012) recognise the challenge for nurses moving to bedside handover: whether it is always appropriate in certain specialities or with some models of nursing care and whether nurses' communication skills are adequate for bedside handover. However despite the challenge of engaging patients in the handover process they conclude that it "supports notions of patient-centred care and the delivery of information at the point of care". Despite recent studies, it has been argued that the impact of the different methods of handover on nursing care and patient outcomes remains unclear (NNRU 2012, Smeulders et al 2014)

The aim of this research was to understand the purpose, impact and experience of nurse-to-nurse handover from both patient and staff perspectives and the perceived differences between nurse handover and medical ward rounds.

METHODS

We conducted a qualitative study on two acute wards at a large UK Trust: one medical and one surgical, both with a rapid turnover of patients and predominately emergency admissions. Researchers conducted semi-structured interviews with staff and patients exploring their experience of communication. Interviews covered:

- the structure, methods and effectiveness of communication within the multidisciplinary team (MDT) and between staff and patients;
- the perceived purpose of the medical ward round and nurse handover;
- the views of staff and patients regarding the role of the patient in ward rounds and nurse handovers;
- and their rating of care on the ward if/when they completed the Family and Friends test (FFT)¹.

Participants were selected using convenience sampling. The criteria for selection for patients: they must be well enough to sustain an interview of at least 30 minutes, able to give written consent and to read and speak English. The Nurse in Charge (NIC) of the shift advised the researcher which patients were eligible for interview. Those patients were approached by the researcher, given a participant information leaflet and either interviewed on the day or at a mutually convenient date. All staff were eligible for participation, they were informed of the study through staff meetings, email and fliers and participants were selected according to availability and willingness to be interviewed when the researchers visited the ward or by prior arrangement at a time that suited the ward rota.

Researchers conducted observations of the ward routine including staff/patient interactions, joined four ward rounds and attended 12 nurse office or station handovers, 3 Multidisciplinary team meetings and 12 bedside handovers. Field notes were taken of all observations and used as part of the analysis.

In total eight patients, ten nurses, one student nurse, three health care assistants, one doctor and one physiotherapist were interviewed. All participants gave written consent. The interviews were recorded and transcribed verbatim by a professional transcriber. The transcriptions were read and re-read by two authors and coded using a pragmatic thematic analysis (Fereday and Muir-Cochrane 2006). Data were managed using NVIVO. Verbatim quotes are indicated by italics and participant number in the results section.

The study was approved by NRES Committee South West-Frenchay Ethics committee (reference number 124328).

Setting

¹ For information on the Family and Friends Test, please see:
<http://www.nhs.uk/NHSEngland/AboutNHSServices/Pages/nhs-friends-and-family-test.aspx>

The medical ward had 23 beds and the surgical ward 26 beds (including a four bed High Dependency Unit). Both wards had a mixture of multi-bed bays and single-bed rooms. On the medical ward each day there were three MDT meetings, two medical ward rounds (morning and afternoon by a single medical team) and two nurse handovers between day and night staff. The surgical ward had two MDT meetings and one academic meeting weekly, two surgical ward rounds daily (both in the morning, two surgical teams) and two nurse handovers daily.

Communication within the MDT was predominantly verbal and there was shared electronic and paper patient records and clinical documentation. Daily jobs diaries, held at the nurses' stations, were used for communication between staff on both wards. The medical ward hosted an MDT meeting prior to the ward round every morning. The Allied Health Professionals on the medical ward used information boards at each patient bed recording mobility, eating and drinking. All nurses worked 12-hour shifts. Both wards had a Nurse in Charge (NIC) of each shift who was supernumerary on the day shift only, staffing levels permitting. Most communication between nurses happened informally but there were two points in the day when information was formally handed over from the outgoing to the incoming shift: at the morning and evening handover.

RESULTS

Structure of nurse handover

Several methods of nurse handover were used in combination. The surgical ward had an office-based handover for all staff on the incoming shift delivered by the NIC of the outgoing shift. The medical ward had handover at the nurses' station, where the outgoing NIC handed over to the incoming NIC and the health care assistants. Both wards used a bedside handover where the nurse managing a group of patients handed over to the nurse taking over their management. On the medical ward, bedside handover was simultaneous with the NIC handover. On the surgical ward, it happened after the office-based handover. No set structure of bedside handover practice was observed and the location, style and content appeared to vary according to individual preference on both wards. "Bedside handover" did not always take place at the bedside but happened outside the room if the patient was in a single bed room and some staff chose to handover in the middle of or outside the multi-bed bay. Health care assistants did not participate in the bedside handover on the medical ward whereas on the surgical ward they chose which bedside handover to attend as they were allocated to two bays, for which the handovers were simultaneous.

There appeared to be no guidelines for handover on either ward and no common practice. Staff expressed concerns regarding confidentiality, discomfort at talking about a patient in front of them, lack of privacy leading to divulging sensitive information, and time pressures associated with patient involvement in handover. These concerns appeared to reflect different levels of confidence and experience in managing patient involvement as one Senior Nurse explains:

“You’re running the risk of someone telling you their life story, but there’s ways of dealing with that....say “Is it okay if I come back and talk to you in a few minutes”
[Senior Nurse, Participant 12]

The only common tool used for the office and NIC handover was a printed sheet from the electronic bed management system. However, clinical care information on this system is limited; no other recognised tools were observed.

The length of handover varied from 45 to 90 minutes. However there is only a 30 minute overlap of shifts and, as handover seldom starts promptly, most shifts routinely finish late. Nurses are generally working overtime to complete handover, which is problematic at the end of a busy 12-hour shift.

Purpose of nurse handover

Interviews explored the purpose of the three types of handover. Staff identified different purposes of each but all were viewed as formal information-sharing between nurses

Office based and NIC handovers

The office-based handover was for general overview of all the patients and the ward, including the bed state, admissions and discharges. Nurses felt a general overview was helpful when they were covering other nurses’ patients, particularly when approached by relatives or other staff for information. In addition the NIC gets a complete picture of the ward.

From the researchers’ observations, office handover served as catch-up time on education, Trust updates, informal debriefing and day-to-day team support. Staff commented that office handover often took too long; the allocation of patients happened at the wrong time, i.e. at the end of handover, and the content was too detailed or repetitive and clashed with the ward rounds:

“Do they find it useful I think they probably do...it’s probably a bit ritualistic...if people have had a stressful time that handover can be a release for them” [Senior Nurse, Participant 12]

The NIC handover served the same purpose as the office-based handover but only between the NIC. However several staff on this ward said that they had experience of office-based handovers elsewhere and preferred bedside handovers only, as they were less time consuming.

Bedside handover

During the bedside handover nurses used the charts, to share relevant clinical information about each patient: current health status, care, medications, and outstanding issues but with no consistent format or content for handover. Both staff and patients agreed the bedside handover was for information-sharing between nurses however views varied regarding the role of the patient within handover. We observed that the variations of style affected the degree of patient involvement. Some nurses spoke with hushed voices, looking down at the charts at the end of the bed and not engaging the patient, whilst others stood by the head of

the bed, spoke in normal tones and occasionally asked the patient questions or responded to their concerns. Other nurses were not at the bedside for handover.

Nurses identified the advantages of bedside handover as:

- Introduction of the nurse coming on shift to the patient
- Asking the patient how they are
- Visually checking the patient and the charts
- Opportunity to ask questions of the nurse handing over
- Continuity of information and safety
- Patient hearing the handover
- Patient opportunity to correct misinformation/ask questions

"I think some like hearing what their story is...and you can ask them directly anything you have in doubt..." [Staff Nurse, Participant 2]

"They [nurse] say 'obs are stable' ...they might not match what the obs are saying. You need to see" [Senior Staff Nurse, Participant 10]

"I guess a patient could jump in, if they feel like something hasn't been said right, just to correct them" [Health Care Assistant, Participant 6]

Despite identifying several advantages of bedside handover most nurses still saw the patient's presence as passive.

The disadvantages identified were:

- Talking over the patient
- Breaching confidentiality
- Patient interrupting and slowing down handover
- The patient hearing what was discussed

"It's not nice to hear two people there, talking about them as if they weren't there. It's better to talk directly to them. If that was me, because I've been a patient myself, I'd think it was rude" [Health Care Assistant, Participant 7]

"...you don't want other patients to hear or the patients themselves to hear" [Staff Nurse, Participant 1]

"I don't know what more the patient can really do without slowing down the process, and breaking it up, and making it seem a bit more confusing" [Staff Nurse, Participant 4]

Some of the more senior nurses, who recognised this tension between involvement and 'talking over', felt that it was possible for the nurse to explain what they were doing and that patients would understand.

The health care assistants were partially or wholly excluded from the bedside handover process which is a potential risk:

"The other day one of the nurses didn't inform me, at all, about what was going on in the bay; like which patients were going home, and who was coming in. So I was just

baffled when they'd left, and someone new came in. When I got back from my break, I was just like, "Where's she gone?" She was like, "She's gone home." So I think sometimes, people forget to tell you things, or just feel, maybe, you don't need to know." [Health Care Assistant, Participant 13]

Patient experience of handover

All staff could describe the handover process but this was not the case for all the patients we interviewed. Most patients were aware, sometimes after prompting, of the "bedside handover" but were unaware of the office or station-based handover as they were out of sight, and they were not told about it.

Patients said they felt reassured when staff clearly knew about them. Equally, they felt insecure if the nurse did not appear to know about their care or treatments:

"It gives you a bit more security knowing that everybody knows everything that is going on" [Patient 3]

Patients' views and experience of involvement in handover varied. Some felt involved in the handover:

"They talk to you. They make sure that everything is alright. Most of them are introduced to you" [Patient 6]

Whilst others wanted to be more involved than they were, suggesting that nurses should do the handover at the bedside:

"If there was a deliberate effort to do a handover while I was listening in, and they were just at the end of the bed, I think that would be quite good" [Patient 3]

"Yes. I'd feel like I was involved in the conversation if the handover was here. When it's over there they are just doing their jobs" [Patient 4]

Some patients wanted to hear the handover on their condition but not be involved:

"Yes. I see what's happening is they explain in detail so sometimes I forgot what's happening to me through the night or I am not aware. So when I hear her say xxx, last did this this this, so I learn something about myself" [Patient 7]

and some thought involvement could be a distraction to the nurses:

"...it's their job to communicate with each other and concentrate on what they're doing than trying to involve me when I don't need that" [Patient 8]

One patient described the nurse handover as a "dialogue in his presence" but he felt he could easily interrupt if necessary [Patient 1]. There was general consensus on feeling able to interrupt if something erroneous was said.

However one patient explained how involvement was not always possible even if he had wanted it:

"I was aware. I was less able to get involved because I just wasn't with it" [Patient 3]

There were some negative experiences of handovers either being intrusive at the bedside or taking nurses away from the ward:

"You could ring and ring and ring, and nobody would come. They were all too busy with the handover." [Patient 5]

"Sometimes handover, I was asleep, many times they wake me up..." [Patient 7]

Medical ward rounds

Patients described the medical ward round as an exchange between doctor and patient, not information-sharing between professionals. Patients were aware of the purpose and format, and expected to be seen daily at roughly the same time although sometimes consultants 'dropped in' unexpectedly. In contrast to nurse handover all patients reported feeling involved and well informed:

"...they are talking to me, and asking me questions. Yes, certainly, I am totally involved" [Patient 5]

Nurses were not always present on doctors' ward rounds. Views varied from patients and nurses about how much the nurses were kept informed. Notes were written but not verbally communicated or vice versa. This gap may be connected to the absence of a nurse on the ward round. Nurses were frustrated by the lack of communication:

"Okay we're making our plans for you to go home later in the week' and they say 'the doctor told me I could go home'. They see this massive non-communication between us whereas if the nurse is there on the ward round everyone is in the know" [Senior Nurse, Participant 12]

Nurse involvement is a logistical and workload problem; the two surgical ward rounds happen simultaneously and often clash with the nurse handovers making participation impossible. The NIC had to choose which round to join or sometimes neither if s/he was in handover. Patients commented on the adverse impact of the clash of handover and ward rounds on communication. Patient care priorities usually restricted participation of the bay nurse excluding them from reporting changes and hearing the update on patient care and treatments:

"I usually prefer to go round if it is my patients...I think it is quite important...just so you are up to date with information" [Staff Nurse, Participant 5]

The presence of the NIC on the ward rounds was critical for their role as the 'go between'/'information sharer' between nurses and doctors, doctors and patients/relatives. Ward round timetabling, to avoid the clashes and enable NIC participation, was under discussion towards the end of the study although no resolution had been reached at that time. In contrast nurses reported excellent communication with AHP's both verbal and written:

"They [AHP] are brilliant because they would look for you, even on your break" [Staff Nurse, Participant 1]

Patients' experience of general communication

Patients described how important it was to them to be kept informed of changes in their condition, treatments and care.

“There’s nothing worse than not knowing” [Patient 4]

In general patients were happy with the depth and clarity of staff communication and found it easy to obtain information:

“I just asked the nurse and she found out for me. Or she went and asked someone else and they came in and got what I wanted, yes, with the answers” [Patient 3]

“They were brilliantexplaining everything really well and really clearly about what’s going wrong in plain English” [Patient 4]

However, the rigidity of the ward routine, for example, test results were given on ward rounds, sometimes impacted negatively on patient experience. One patient suggested:

“Just having a five-minute conversation with someone at the end of the day would have stopped all of that anxiety for the people certainly”. [Patient 4]

This patient went further in suggesting that mini updates every 2 hours would be helpful.

Some patients observed a lack of communication between staff:

“I don’t see a great deal of work between the doctors and the nurses. I don’t see a great deal of communication between them” [Patient 5]

He spoke of his experience of nurses not knowing about new drugs prescribed or investigations planned. Both staff and patients on the surgical ward suggested that communication and the patient experience would be enhanced if the NIC was always on the ward round. The researchers observed that the NIC on the medical ward attended a large MDT meeting every morning where s/he fed back changes in the patients’ condition to the MDT and was updated on results, treatment and planned investigations. She then informed each nurse of any updates relevant to their patients.

Finally we conducted one joint interview with a patient and his wife and spoke with some partners/relatives informally during visiting. Patients were very appreciative that their partners had been kept well informed, including being rung at home by staff with updates.

Overall rating of experience

Most patients reported anxiety about coming into hospital because of negative press coverage but were in fact generally satisfied with their overall care. All participants were asked to rate the ward using the FFT. They were either “likely” or “highly likely” to recommend the ward to friends or family:

“...we couldn’t have been treated better if we were the king and the queen of a country. I mean that sincerely” [Patient 6]

Nurses on the surgical ward felt that care and patient experience had improved since a recent increase in staffing and the appointment of a new Ward Manager. This improvement was reflected in the ward’s monthly patient experience survey results.

DISCUSSION

Our study showed, as with Lu et al (2014), that patients wanted information about their condition on a regular basis. The opportunities for information-receiving were generally at set times, primarily via ward rounds, but also, for some patients, the nurse handover. Otherwise information had to be sought by patients through asking questions. Most patients we interviewed were willing and able to ask questions but this may not be the case for all patients, particularly the more vulnerable or those not fluent in English.

The researchers observed variations in practice and a lack of consensus on the purpose and format of nurse handover. Although nurses were critical of the office handover some identified benefits and as with the findings of Hopkinson (2002), the researchers observed that handover was a time to express opinions and feelings and to debrief. Staff had varied views about the role of bedside handover and the involvement of patients. As in other studies, there were concerns about the time and confidentiality associated with patient involvement (Anderson and Mangino 2006; National Nursing Research Unit 2012). Nurses concerns about confidentiality resulted in nurses doing 'bedside handover' not at the bedside (Johnson and Cowan 2012). However, it is seen as possible and beneficial to involve patients in handover (Anderson & Mangino 2006; Laws and Amato 2010) and is a further step towards patient centred care (Johnson and Cowan 2012). Senior nursing staff remarked on the competence, experience and confidence needed to involve patients in handover; this concern was highlighted by patients in Lu et al (2014) study for which they suggested providing the relevant training.

Although the researchers found that patients' views on involvement in bedside handover varied the present study concurs with Lu et al (2014) that patients' valued bedside handover as an opportunity to receive information, to correct errors and give additional information regarding their condition.

Patients' perception of the quality of communication and interaction during their hospital stay was also varied. Experience was far more nuanced than a simple "good" or "poor", and all participants cited a range of experiences. Despite the high ratings given, this variation may make it hard for patients to make simplistic choices when asked to rate their experience, via tools, such as the FFT, which yield insufficient material to guide the health service to improve experience.

Recommendations for clinical practice at handover focus on three aspects, suggesting that handovers should be standardised, structured, and in written form. Mnemonics are thought to have a role in improving the quality of handover (Riesenberg et al. 2009; Spranzi 2014) although we did not observe their use during the study. The Cochrane review by Smeulers et al (2014) suggested that based on current knowledge handovers should also be face to face and involve patients. Handover is recognised as a critical time in patient care. The quality and content of handover has major implications for patient safety, and influences both patient and staff experience.

Twelve hour nursing shifts mean that the outgoing shift is always due to go off duty after handover which is not the case for the middle shift in a three shift system, where there is built-in overlap. This change in shift patterns may have made handover more pressurised.

This pressure adds to professional anxiety about handover (Wong, Yee, & Turner 2008). Mnemonics and structured handover may help ameliorate the pressure and streamline the process.

Limitations

This study was conducted in a single Trust and only two wards. Practice elsewhere may be different. There was no interpreting service available to the study, due to limited funding, which may have excluded some of the more vulnerable patients that would be expected to be inpatients in an inner city hospital. The researchers relied on clinical staff to identify the patients who were 'fit enough' to be interviewed which also may have introduced a bias by excluding the most unwell patients.

CONCLUSION

It may not be necessary to introduce a standardised handover; different wards and specialties have different needs. However, the purpose of each communication can be agreed and clarified with all professionals. The medical ward round enables communication, within multidisciplinary teams and with patients. The nursing group/management handover is for nurse managers to communicate with each other and their teams. Bedside handover is for one-to-one nurse communication about an individual patient, preferably with the involvement of the patient. The teams need to address the communication needs of HCA's regarding bedside handover. Teams need to agree their model of handover and develop the structure, content and style accordingly. The use of existing mnemonics or tools could be considered.

Ward-level training for nurses to develop competence and confidence in bedside handover will be useful. Patient information in plain English on the purpose and timings of handovers/ward rounds and their own role within them, is important to promote patient-centred care. Efforts are required to ensure that medical ward rounds and nurse handover do not clash. Confident, clear, pro-active communication by staff at times and in formats clearly understood by the patient would reassure patients that staff know what is happening to them, and why, and enhance their experience.

The findings will be used to inform the future development of nurse handover and to guide patient involvement as part of the Trust's strategic aim to improve communication. The Trust is developing a nurse handover module for its forthcoming electronic patient record and these findings have informed the format and content.

REFERENCES

- Anderson, C.D. & Mangino, R.R. 2006. Nurse shift report: who says you can't talk in front of the patient? *Nursing Administration Quarterly*, 30, (2) 112-122
- Anderson, J., Malone, L., Shanahan, K., Manning, J. 2014. Nursing bedside clinical handover - an integrated review of issues and tools. *Journal of Clinical Nursing*, 24, 662-671.
- Australian Commission on Safety & Quality in Health Care. Safety and Improvement Quality Guide Standard 6: Clinical Handover (October 2012). Sydney. ACSQHC, 2012
- Bradley, S. & Mott, S. 2013. Adopting a patient centred approach: an investigation into the introduction of bedside handover to three rural hospitals. *Journal of Clinical Nursing*, 23, 1927-1936.
- British Medical Association Junior Doctors Committee 2004, *Safe handover: safe patients. Guidance on clinical handover for clinicians and managers*, British Medical Association, London.
- Cahill, J 1998 *Patients perceptions of bedside handover* Journal of Clinical Nursing, 7, 351-359
- Epstein, R.M., Fiscella, K., Lesser, C.S., & Strange, K.C. 2010. Why the nation needs a policy push on patient-centered health care. 2010;29(8):1489-1495. *Health Aff (Millwood)*, 29, (8) 1489-1495
- Fereday J, Muir-Cochrane E (2006) Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods* 5(1)
- Gage, W. 2013. Evaluating handover practice in an acute NHS Trust. *Nursing Standard*, 27, (48) 43-50
- Greaves, C. 1999. *Patients perceptions of bedside handover*. Nursing Standard, 14, 32-35
- Hopkinson, J. 2002. The hidden benefit: The supportive function of the nursing handover for qualified nurses caring for people dying in hospital. *Journal of Clinical Nursing*, 11, 168-175
- Kerr, M. 2002. A qualitative study of shift handover practice and function from a socio-technical perspective. *Nursing and Health Care Management Issues*, 37, 125-134
- Kerr, D., McKay, K., Klim, S., Kelly, A-M., McCann, T. 2013. Attitudes of emergency department patients about handover at the bedside. *Journal of Clinical Nursing*, 23, 1685-1693
- Johnson, M., Cowin, L. 2013. *Nurses discuss bedside handover and using written handover sheets*. Journal of Nursing Management, 21, 121-129
- Laws, D. & Amato, S. 2010. Incorporating bedside reporting into change-of-shift report. *Rehabilitation Nursing*, 35, (2) 70-74

Lu, S., Kerr, D., McKinlay, L. 2014 *Bedside nursing handover: Patients' opinion*. International Journal of Nursing Practice, 20, 451-459

Maxson PM, Derby KM, Wroblewski DM, Foss DM (2012) Bedside nurse-to-nurse handoff promotes patient safety. *Medsurg Nurs* 21 (3):140-4

McMurray, A., Chaboyer, W., Wallis, M., Fetherston, C. 2010 Implementing Bedside Handover: strategies for change management *Journal of Clinical Nursing* , 19, 2580-2589

National Nursing Research Unit 2012. What are the benefits and challenges of "bedside" nursing handovers? *Policy +, National Nursing Research Unit, King's College London* (36) 1-2

Neale, G., Woloshynowych, M., & Vincent, C. 2001. Exploring the causes of adverse events in NHS hospital practice. *Journal of the Royal Society of Medicine*, 94, (7) 322-330

Riesenberg, L.A., Leitzsch, J., & Little, B.W. 2009. Systematic review of handoff mnemonics literature. *Am J Med Qual*, 24, (3) 196-204

Smeulders M, Lucas C, Vermeulen H (2014) Effectiveness of different nursing handover styles for ensuring continuity of information in hospitalised patients. *Cochrane Database Syst Rev* 6:CD009979.doi:10.1002/14651858.CD009979.pub2

Spranzi, F. 2014. Clinical handover on labour ward: a narrative synthesis of the literature. *British Journal of Midwifery*, 22, (10) 625-632

Street, M., Eustace, P., Livingston, P., Craike, M., Kent, B., Patterson, D. 2011. Communication at the bedside to enhance patient care: a survey of nurses' experience and perspective of handover *International Journal of Nursing Practice* 17 133-140.

Wong MC, Yee KC, Turner P (2008) A Structured Evidence-based Literature Review regarding the Effectiveness of Improvement Interventions in Clinical Handover. Prepared by eHealth Services Research Group, University of Tasmania, for the Australian Commission on Safety and Quality in Health Care. <http://tinyurl.com/glws3oh> (accessed 30 March 2016)

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