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**Literature search results**

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**Best practice in handover including nurse-to-nurse shift handover and ward-to-ward handover.**

**Resources searched**

NHS Evidence; TRIP Database; Cochrane Library; CINAHL; EMBASE; HMIC; Health Business Elite; MEDLINE; Google Scholar; Google Advanced Search

**Database search terms:** handover; hand-over; “hand over”; handoff; hand-off; “hand off”; information adj2 transfer; HAND OFF (PATIENT SAFETY); changeover; change-over; patient* adj2 transfer*; patient* adj3 care; shift*; nurs*; ward*; nurse-to-nurse OR "nurse to nurse"; SBAR; "situation-background-assessment-recommendation";

**Google search string:** (handover OR hand-over OR “hand over” OR handoff OR hand-off OR “hand off” OR changeover OR change-over OR "change over" OR SBAR) (nurse OR nurses OR nursing OR shift OR shifts OR ward OR wards) healthcare

**Summary**

There is a great deal of research into handover, although not a lot of guidance or evidence-based reviews on the subject. SBAR seems one of the more common techniques for improving communication at handover, but there are others. Also included is research on the effects of poor handover between clinicians.

**Guidelines**

**Association of Anaesthetists of GB and Ireland**

AAGBI safety guideline - interhospital transfer 2009
See section 9 on Documentation and handover.
Using SBAR helped raise the profile of our EWS and how to use it,’ said the general manager of medicine at Bradford Teaching Hospitals. ‘To introduce SBAR, we provided online training to both outreach team members and frontline staff. We also used plan, do, study, act to incorporate SBAR into communications and encouraged outreach team members to only accept calls in SBAR.’

**HealthPress Publishing**

*What works: effective tools and case studies to improve clinical office practice* 2004

1. We have noted that when we add too many resources to a process, no more work is accomplished. Too much time is wasted on hand-offs and unnecessary communication. No one seems to know who is doing what.

2. When postponed work is handed off to another person, completion is further delayed by a second learning curve. Handing off also increases the potential for error. From referrals to appointments, doing it now saves rework and delays.

**NICE**

*Improving supportive and palliative care for adults with cancer: the manual* 2007

See section D2 *Communication, co-ordination and continuity*

Further examples of tools used to improve communication and co-ordination within and between teams include multidisciplinary meetings, case conferences, unified assessment tools and hand-over forms. The value of these tools remains unsubstantiated.

**Powys Local Health Board: Clinical Leadership Programme**

*Patient Care Handover - A Standardised Format*

**RAND Europe**

*Achieving strong teamwork practices in hospital labor and delivery units* 2010

**Royal College of Obstetricians and Gynaecologists**

*Improving patient handover (Good Practice No 12)* 2010

The SBAR (situation – background – assessment – recommendation) tool, may be useful as it can be used to efficiently hand over individual patients in approximately 30–60 minutes. Introducing a system such as SBAR into inter-professional communication not only improves the efficiency of communication, it also allows all members of the team lower down the hierarchy to add to the conversation in an organised fashion.

**Royal College of Surgeons**


See the *Handovers at a glance* section

**Evidence-based reviews**
## Published research

1. **Multidisciplinary teamwork and communication training.**
   
   **Author(s):** Deering S, Johnston LC, Colacchio K  
   
   **Citation:** Seminars in Perinatology, April 2011, vol./is. 35/2(89-96), 0146-0005;1558-075X (2011 Apr)  
   
   **Publication Date:** April 2011  
   
   **Abstract:** Every delivery is a multidisciplinary event, involving nursing, obstetricians, anesthesiologists, and pediatricians. Patients are often in labor across multiple provider shifts, necessitating numerous handoffs between teams. Each handoff provides an opportunity for errors. Although a traditional approach to improving patient outcomes has been to address individual knowledge and skills, it is now recognized that a significant number of complications result from team, rather than individual, failures. In 2004, a Sentinel Alert issued by the Joint Commission revealed that most cases of perinatal death and injury are caused by problems with an organization's culture and communication failures. It was recommended that hospitals implement teamwork training programs in an effort to improve outcomes. Instituting a multidisciplinary teamwork training program that uses simulation offers a risk-free environment to practice skills, including communication, role clarification, and mutual support. This experience should improve patient safety and outcomes, as well as enhance employee morale. Published by Elsevier Inc.

2. **Patients' perspectives of bedside nursing handover.**  
   
   **Author(s):** McMurray, Anne, Chaboyer, Wendy, Wallis, Marianne, Johnson, Joanne, Gehrke, Tanya  
   
   **Citation:** Collegian, 01 March 2011, vol./is. 18/1(19-26), 13227696  
   
   **Publication Date:** 01 March 2011  
   
   **Abstract:** Background Patient participation in handover is one aspect of patient-centred care, where patients are considered partners in care. Understanding the patient perspective provides a foundation for nurses to tailor their bedside handovers to reflect patients' thoughts and beliefs and encourage their active involvement in decision-making. Aim This study examined patients' perspectives of participation in shift-to-shift bedside nursing handover. Methods A descriptive case study was conducted with 10 patients in one Queensland hospital who had experienced bedside handover during their hospitalisation in 2009. Participants were asked their views about bedside handover including its benefits and limitations, their existing and potential role in handover, the role of family members, and issues related to confidentiality. Data were analysed using thematic content analysis. Findings Four themes emerged from the analysis. First, patients appreciated being acknowledged as partners in their care. Second, they viewed bedside handover as an opportunity to amend any inaccuracies in the information being communicated. Third, some preferred passive engagement rather than being fully engaged in the handover. Fourth, most patients appreciated the inclusive approach of handover as nurse-patient interaction. Conclusions Bedside handover provides an opportunity for patients to be involved as active participants in their care. They value having access to information on an ongoing basis, and although not all choose the same level of interaction, they see their role as important in maintaining accuracy, which promotes safe, high quality care.

3. **Review: bringing patient safety to the forefront through structured computerisation during clinical handover.**  
   
   **Author(s):** Matic J, Davidson PM, Salamonson Y  
   
   **Citation:** Journal of Clinical Nursing, 01 January 2011, vol./is. 20/1/2(184-189), 09621067
Abstract: This review aims to examine critically, the methods and modes of delivery of handover used in contemporary health care settings and explore the feasibility of a computerised handover system for improving patient safety. Clinicians play a critical role in promoting patient safety, and the handover ritual is recognised as important in exchanging information and planning patient care. Communication failures have been identified as an important cause of adverse incidents in hospitals. Integrative literature review. Search of multiple electronic databases using terms: nursing handover, handoff, shift-to-shift reporting and change of shift report. To date, the focus of research has primarily been on the vehicle of the handover, rather than the content and processes involved in ensuring the reliability and quality of clinical information. Employing a computerised handover system in the clinical arena has the potential to improve the quality and safety of clinical care. Whilst the handover performed from shift-to-shift is a valuable communication strategy, ambiguities and incomplete information can increase the risks of adverse events. Given the importance of effective communication, its key link to patient safety and the frequency of nursing handover, it is imperative that clinical handover undergo increased scrutiny, development and research. This review underscores the challenge in clinical handover and recommends the use of technological solutions to improve communication strategies.

Source: CINAHL

Full Text:
Available in fulltext at Ovid

4. Improving transitions in inpatient and outpatient care using a paper or web-based journal.

Author(s): Singh R, Roberts AC, Singh A, Heider AR, Norris T, Porreca D, Singh G

Citation: JRSM Short Reports, 2011, vol./is. 2/2(6), 2042-5333 (2011)

Publication Date: 2011

Abstract: OBJECTIVE: To develop a ‘Transitions Journal’ for inter-unit and inter-setting communication for improving quality and safety of care and patient satisfaction with timely, reliable and meaningful information for all stakeholders.DESIGN: Front-line staff were targeted in a series of four team meetings through which this ‘Journal’ was developed iteratively; initially as a paper-based and subsequently as an IT-based tool. Goals were to: (1) develop a standardized tool based on SBAR format (Situation, Background, Assessment, Recommendation); (2) facilitate improved communication at the points of care; (3) use a bottom-up approach; (4) create situational awareness and facilitate team formation; and (5) create visual workflow models to help inculcate a culture of safety.SETTING: A 183-bed community-hospital and its Primary Care Center, in an urban area in western New York State.PARTICIPANTS: Ten nurses and 12 physicians representing both the hospital and primary care center participated voluntarily.MAIN OUTCOME MEASURES: (1) Successful development of the ‘Transitions Journal’; and (2) identification of its potential uses.RESULTS: (1) Development: the journal was successfully developed in both paper and web-based formats; (2) identification of uses: participants recommended using the tool as a checklist to verify appropriate communication at both the sending and receiving ends; as an audit tool for retrospective review of handoffs; and as a teaching tool.CONCLUSIONS: A journal developed by and for front-line staff has the potential to provide opportunities for improvement, instill a systems approach, improve care continuity, improve compliance with safety goals, improve patient and staff satisfaction, reduce duplication and costs, inculcate teamwork, and provide mutual emotional and intellectual support. Further work to evaluate and disseminate this tool is in progress.

Source: MEDLINE

Full Text:
Available in fulltext at Highwire Press
Available in fulltext at National Library of Medicine

5. Handover in the perioperative care process.
PURPOSE OF REVIEW: To summarize recent developments in the study of perioperative handovers, when patients are transferred between various hospital locations (emergency room, ward, operating room, recovery room, intensive care unit) and handovers between care providers (doctors and nurses) when changing shifts. RECENT FINDINGS: There has been tremendous activity in studying handovers during the last 2 years, and many potential improvements were developed, implemented and evaluated in real-life care settings. In hospitals that have electronic patient records (EPRs), a promising approach is to support the various verbal handover processes with software tools that can combine specific handover items such as to-do lists, daily goals, and concerns, with automatically extracted data from the EPRs. SUMMARY: There is now widespread consensus that robust, structured handover processes are critical for safe patient care. Checklists and software tools to facilitate the handover process may improve the reliability of handovers and relieve the stress on residents of handing over their patients to the incoming resident. However, there is no 'one size fits all' solution to the problems of handover. Handover improvements will need to be tailored to the specific care setting and handover type.

Source: CINAHL

Full Text: Available in fulltext at Ovid

6. Assessing the quality of patient handoffs at care transitions.

BACKGROUND: Effective handoff practices (ie, mechanisms for transferring information, responsibility and authority) are critical to ensure continuity of care and patient safety.OBJECTIVE: This study aimed to develop a rating tool (self-rating and external rating) for handoff quality that goes beyond mere information transfer.METHODS: The rating tool was piloted during 126 patient handoffs performed in three different clinical settings in a tertiary care hospital: (1) paramedic to emergency room staff, (2) anaesthesia care provider to postanaesthesia care unit (PACU) and (3) PACU nurse to ward nurse.RESULTS: We identified three factors (information transfer, shared understanding, working atmosphere) predicting handoff quality.CONCLUSIONS: This study provides insights into the multidimensional concept of handoff quality. Our rating tool is feasible and comprehensive by including not only characteristics of the information process but also aspects of teamwork and, thus, provides an important tool for future research on patient handoff.

Source: MEDLINE

7. Changing handoffs: The shift is on.

The article focuses on the need for bringing changes in the handoff communication in order to improve the nursing shift report, nursing documentation and patient outcomes in the U.S. A report from the Institute of Medicine, which cites the lack of teamwork as a key reason for poor patient outcomes, stresses the need for collaborative team works to improve the patient safety. It discusses the success of various changes brought into the system of shift report at a medical-surgical unit at Brigham and Women's Hospital in Boston, Massachusetts including allowing the unlicensed assistive personnel to
listen to the shift report.


Author(s): McArthur A

Citation: Journal of Advanced Nursing, 01 September 2010, vol./is. 66/9(1935-1936), 03092402

Publication Date: 01 September 2010

Source: CINAHL


Author(s): McMurray A, Chaboyer W, Wallis M, Fetherston C

Citation: Journal of Clinical Nursing, 01 September 2010, vol./is. 19/17/18(2580-2589), 09621067

Publication Date: 01 September 2010

Abstract: Aims and objectives. To identify factors influencing change in two hospitals that moved from taped and verbal nursing handover to bedside handover. Background. Bedside handover is based on patient-centred care, where patients participate in communicating relevant and timely information for care planning. Patient input reduces care fragmentation, miscommunication-related adverse events, readmissions, duplication of services and enhances satisfaction and continuity of care. Design. Analysing change management was a component of a study aimed at developing a standard operating protocol for bedside handover communication. The research was undertaken in two regional acute care hospitals in two different states of Australia. Method. Data collection included 532 semi-structured observations in six wards in the two hospitals and 34 in-depth interviews conducted with a purposive sample of nursing staff involved in the handovers. Observation and interview data were analysed separately then combined to generate thematic analysis of factors influencing the change process in the transition to bedside handover. Results and conclusion. Themes included embedding the change as part of the big picture, the need to link the project to standardisation initiatives, providing reassurance on safety and quality, smoothing out logistical difficulties and learning to listen. We conclude that change is more likely to be successful when it is part of a broader initiative such as a quality improvement strategy. Relevance to clinical practice. Nurses are generally supportive of quality improvement initiatives, particularly those aimed at standardising care. For successful implementation, change managers should be mindful of clinicians' attitudes, motivation and concerns and their need for reassurance when changing their practice. This is particularly important when change is dramatic, as in moving from verbal handover, conducted in the safety of the nursing office, to bedside handover where there is greater transparency and accountability for the accuracy and appropriateness of communication content and processes.

Source: CINAHL

10. Using SBAR to communicate falls risk and management in inter-professional rehabilitation teams.

Author(s): Andreoli A, Fancott C, Velji K, Baker GR, Solway S, Aimone E, Tardif G

Citation: Healthcare Quarterly, September 2010, vol./is. 13 Spec No/(94-101), 1710-2774;1710-2774 (2010 Sep)

Publication Date: September 2010
Abstract: This study implemented and evaluated the adapted Situation-Background-Assessment-Recommendation (SBAR) tool for use on two inter-professional rehabilitation teams for the specific priority issue of falls prevention and management. SBAR has been widely studied in the literature, but rarely in the context of rehabilitation and beyond nurse-physician communication. In phase one, the adapted SBAR tool was implemented on two teams with a high falls incidence over a six-month period. In phase two, process and outcome evaluations were conducted in a pre-post design comparing the impact of the intervention with changes in the rest of the hospital, including the perceptions of safety culture (as measured by the Hospital Survey on Patient Safety Culture); effective team processes, using the Team Orientation Scale; and safety reporting, including falls incidence, severity and near misses. This study suggests that the adapted SBAR tool was widely and effectively used by inter-professional rehabilitation teams as part of a broader program of safety activities. Near-miss and severity of falls incidence trended downward but were inconclusive, likely due to a short time frame as well as the nature of rehabilitation, which pushes patients to the limit of their abilities. While SBAR was used in the context of falls prevention and management, it was also utilized it in a variety of other clinical and non-clinical situations such as transitions in care, as a debriefing tool and for conflict resolution. Staff found the tool useful in helping to communicate relevant and succinct information, and to "close the loop" by providing recommendations and accountabilities for action. Suggestions are provided to other organizations considering adopting the SBAR tool within their clinical settings, including the use of an implementation tool kit and video simulation for enhanced uptake.

Source: MEDLINE


Author(s): Mulligan LA

Citation: Clinical Nurse Specialist: The Journal for Advanced Nursing Practice, 01 July 2010, vol./is. 24/4(216-217), 08876274

Publication Date: 01 July 2010

Source: CINAHL


Citation: Archives of Surgery, June 2010, vol./is. 145/6(582-8), 0004-0010;1538-3644 (2010 Jun)

Publication Date: June 2010

Abstract: HYPOTHESIS: Health care failure mode and effect analysis identifies critical processes prone to information transfer and communication failures and suggests interventions to improve these failures.DESIGN: Failure mode and effect analysis.SETTING: Academic research.PARTICIPANTS: A multidisciplinary team consisting of surgeons, anesthetists, nurses, and a psychologist involved in various phases of surgical care was assembled.MAIN OUTCOME MEASURES: A flowchart of the whole process was developed. Potential failure modes were identified and evaluated using a hazard matrix score. Recommendations were determined for certain critical failure modes using a decision tree.RESULTS: The process of surgical care was divided into the following 4 main phases: preoperative assessment and optimization, preprocedural teamwork, postoperative handover, and daily ward care. Most failure modes were identified in the preoperative assessment and optimization phase. Forty-one of 132 failures were classified as critical, 26 of which were sufficiently covered by current protocols. Recommendations were made for the remaining 15 failure modes.CONCLUSIONS: Modified health care failure mode and effect analysis proved to be a practical approach and has been well received by clinicians. Systematic analysis by a multidisciplinary team is a useful method for detecting failure modes.
13. The tangible handoff: a team approach for advancing structured communication in labor and delivery

**Author(s):** Block M., Ehrenworth J.F., Cuce V.M., Ng'ang'a N., Weinbach J., Saber S.B., Milic M., Urgo J.A., Sokoli D., Schlesinger M.D.

**Citation:** Joint Commission journal on quality and patient safety / Joint Commission Resources, June 2010, vol./is. 36/6(282-287, 241), 1553-7250 (Jun 2010)

**Publication Date:** June 2010

**Abstract:** The tangible handoff tool, a standardized, patient-specific, two-sided pocket card that guides nurses through transfer of care at each shift, is intended to improve continuity and coordination of care in labor and delivery.


**Author(s):** Welsh CA, Flanagan ME, Ebright P

**Citation:** Nursing Outlook, 01 May 2010, vol./is. 58/3(148-154), 00296554

**Publication Date:** 01 May 2010

**Abstract:** During a handoff, communication errors can lead to adverse events and suboptimal patient care. As a result, many institutions want to redesign their handoff processes, but have little specific guidance from the literature. We examined two approaches to nursing end-of-shift reports both taped and written, to identify specific factors limiting and facilitating such handoffs. Twenty nurses were interviewed using a semistructured format. They were asked about the current reporting process, the limitations, the elements that helped, and ideas for improvement. Analyses revealed that inadequate information, inconsistent quality, limited opportunity to ask questions, equipment malfunction, insufficient time to generate reports, and interruptions, limited handoffs. Facilitators were “pertinent” content, notes and space for notes, face-to-face interaction, and structured form/checklist. Recommendations for redesign are defining content pertinent to the unit, structuring handoffs so that information is received in a standard way, embedding an opportunity for questions into the process, planning for all 3 handoff subprocesses, and conducting peer evaluations and education.

15. The challenges of implementing an electronic nursing clinical handover in a neonatal intensive care unit

**Author(s):** Hua C.

**Citation:** Journal of Paediatrics and Child Health, March 2010, vol./is. 46/(29), 1034-4810 (March 2010)

**Publication Date:** March 2010

**Abstract:** Background: A tool has been created within the Neonatal Database for Nurses to handover between shifts. The database is accessed from all departmental PCs as well as a wireless laptop at the bedside during rounds. Medical, Nursing and Allied Health staff share information relevant to the management of the infant and family, and each enter data specific to their role. Team leaders are encouraged to work directly from the live system during rounds and handover, but have the option to print out a Team Leader worksheet. Progressing from traditional handover to live electronic handover faces challenges related to socio culture set within the NICU, personal experience in using technology, and willingness to accept change in practice. Method: A neonatal working party has been formed to discuss objectives and methods on how to implement changes in the NICU by having monthly meetings. The nursing handover module has continued to be reviewed, redesigned and updated following feedback from the users to ensure the clinical
information is clear, simple, and user friendly. Results: Some team leaders readily adapt and are keen to use the electronic handover but uptake is not uniform. Issues raised were length of time spent on updating the clinical information, unfamiliarity with the module and lack of efficient personal computer skills. Conclusions: Safe clinical handover is a priority for NSW health. An electronic clinical handover tool can be successfully implemented by staff who are keen to accept the new practice with adequate orientation, training and support by nursing and departmental management.

Source: EMBASE

Full Text:
Available in fulltext at EBSCO Host


Author(s): Chaboyer W, McMurray A, Wallis M

Citation: International Journal of Nursing Practice, 01 February 2010, vol./is. 16/1(27-34), 13227114

Publication Date: 01 February 2010

Abstract: A case study of six wards in two hospitals was undertaken to describe the structures, processes and perceptions of outcomes of bedside handover in nursing. A total of 532 bedside handovers were observed and 34 interviews with nurses were conducted. Important structural elements related to the staff, patients, the handover sheet and the bedside chart. A number of processes before, during and after the handover were implemented. They included processes for managing patients and their visitors, sensitive information, and the flow of communication for variable shift starting times. Other key processes identified were the implementation of a safety scan and medication check. The situation, background, assessment and recommendations approach was used only in specific circumstances. Perceived outcomes were categorized as improving accuracy and service delivery, and promoting patient-centred care. Although the move to bedside handover is not the norm, it reflects a patient-centred approach.

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host

17. Role of the nurse-to-nurse handover in patient care.

Author(s): Scovell S

Citation: Nursing Standard, 20 January 2010, vol./is. 24/20(35-39), 00296570

Publication Date: 20 January 2010

Abstract: The nurse-to-nurse handover is not taught formally during training, yet it is one of the most important rituals of the nursing shift. This article focuses on the structure and function of change-of-shift reports and lists the events that occur within them, describing the locations of the handover process and the mode of communication involved. The problems that can occur during handover are discussed and solutions are proposed.

Source: CINAHL

Full Text:
Available in fulltext at Ovid
Available in fulltext at EBSCO Host
Available in print at Louth County Hospital Medical Library

18. The effect of the COACH program (Continuity Of Appropriate pharmacotherapy, patient Counselling and information transfer in Healthcare) on readmission rates in a multicultural population of internal medicine patients.

Author(s): Karapinar-Carkit F, Borgsteede SD, Zoer J, Siegert C, van Tulder M, Egberts AC, van den Beemt PM
BACKGROUND: Medication errors occur frequently at points of transition in care. The key problems causing these medication errors are: incomplete and inappropriate medication reconciliation at hospital discharge (partly arising from inadequate medication reconciliation at admission), insufficient patient information (especially within a multicultural patient population) and insufficient communication to the next health care provider. Whether interventions aimed at the combination of these aspects indeed result in less discontinuity and associated harm is uncertain. Therefore the main objective of this study is to determine the effect of the COACH program (Continuity Of Appropriate pharmacotherapy, patient Counselling and information transfer in Healthcare) on readmission rates in patients discharged from the internal medicine department.

METHODS/DESIGN: An experimental study is performed at the internal medicine ward of a general teaching hospital in Amsterdam, which serves a multicultural population. In this study the effects of the COACH program is compared with usual care using a pre-post study design. All patients being admitted with at least one prescribed drug intended for chronic use are included in the study unless they meet one of the following exclusion criteria: no informed consent, no medication intended for chronic use prescribed at discharge, death, transfer to another ward or hospital, discharge within 24 hours or out of office hours, discharge to a nursing home and no possibility to counsel the patient. The intervention consists of medication reconciliation, patient counselling and communication between the hospital and primary care healthcare providers. The following outcomes are measured: the primary outcome readmissions within six months after discharge and the secondary outcomes number of interventions, adherence, patient's attitude towards medicines, patient's satisfaction with medication information, costs, quality of life and finally satisfaction of general practitioners and community pharmacists. Interrupted time series analysis is used for data-analysis of the primary outcome. Descriptive statistics is performed for the secondary outcomes. An economic evaluation is performed according to the intention-to-treat principle.

DISCUSSION: This study will be able to evaluate the clinical and cost impact of a comprehensive program on continuity of care and associated patient safety.

TRIAL REGISTRATION: Dutch trial register: NTR1519.

Source: MEDLINE

Full Text:

Available in fulltext at BioMedCentral

Available in fulltext at National Library of Medicine

19. Point of care documentation impact on the nurse-patient interaction.

Author(s): Duffy WJ, Kharasch MS, Du H

Citation: Nursing Administration Quarterly, January 2010, vol./is. 34/1(E1-E10), 0363-9568;1550-5103 (2010 Jan-Mar)

Publication Date: January 2010

Abstract: Electronic medical record (EMR) point-of-care (POC) documentation in patients' rooms is a recent shift in technology use in hospitals. POC documentation reduces inefficiencies, decreases the probability of errors, promotes information transfer, and encourages the nurse to be at the bedside. However, EMR POC documentation has the potential to distract the nurse's attention away from the patient and compromise the nurse-patient interaction.

Source: MEDLINE

20. Role of the nurse-to-nurse handover in patient care.

Author(s): Scovell, Sles

Citation: Nursing Standard, 2010, vol./is. 24/20(35-39)

Publication Date: 2010

Abstract: The nurse-to-nurse handover is not taught formally during training, yet it is one of
the most important rituals of the nursing shift. This article focuses on the structure and function of change-of-shift reports and lists the events that occur within them, describing the locations of the handover process and the mode of communication involved. The problems that can occur during handover are discussed and solutions are proposed. 23 refs. [Introduction]

Source: HMIC

Full Text:
Available in fulltext at Ovid
Available in fulltext at EBSCO Host
Available in print at Louth County Hospital Medical Library

21. Using a communication framework at handover to boost patient outcomes.

Author(s): Christie P, Robinson H

Citation: Nursing Times, 01 December 2009, vol./is. 105/47(13-15), 09547762

Publication Date: 01 December 2009

Abstract: This article provides nurses with a simple structure to aid effective communication. It explains how one trust implemented the situation-background-assessment-recommendation (SBAR) structure to improve patient handover, and outlines the benefits for nurses and patients.

Source: CINAHL

Full Text:
Available in fulltext at Ovid
Available in print at Lincoln County Hospital Professional Library
Available in print at Pilgrim Hospital Staff Library

22. Improved record-keeping with reading handovers.

Author(s): Tucker A, Brandling J, Fox P

Citation: Nursing Management - UK, 01 December 2009, vol./is. 16/8(30-34), 13545760

Publication Date: 01 December 2009

Abstract: Nursing handover has traditionally been performed orally and apart from patients. Results of an audit undertaken at the Royal United Hospital, Bath, suggest that record-keeping standards there were poor. To improve these standards, a method of 'reading handover', in which the main method of communication between nurses on different shifts is written rather than oral, was introduced on one ward. This article discusses the results of this pilot study and suggests that the new handover method has improved standards of record keeping.

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host
Available in fulltext at EBSCO Host

23. The development of a tool to facilitate handover from the emergency department to inpatient wards... 2009 CENA International Conference for Emergency Nursing.

Author(s): Heard J, Looney C

Citation: Australasian Emergency Nursing Journal, 01 December 2009, vol./is. 12/4(178-178), 15746267

Publication Date: 01 December 2009

Source: CINAHL
24. Communication and team building skills in the cardiovascular intensive care unit

Author(s): O'Brien M., Hogan C., Ahern J., Almodovar M.

Citation: Cardiology in the Young, November 2009, vol./is. 19/(157), 1047-9511 (November 2009)

Publication Date: November 2009

Abstract: Background: In 2005, nationally there were 2500 sentinel events reported to the Joint Commission. The root cause of greater than 70% of these sentinel events was determined to be a communication failure amongst team members and 70% of pts involved in these sentinel events died as a result. A group of CICU physicians and nurses at a tertiary care pediatric teaching hospital developed an educational program to reinforce communication strategies in the clinical setting and improve teamwork skills during times of crisis. Methods: From November 2006 through February 2008, five audits were randomly performed on the day shift each month during organized times of rounds and transfers (nurse to nurse report and admission from the operating room, the cardiac catheterization lab) to assess for the presence of 16 effective communication techniques. In March 2008, five additional audits were performed which concentrated on times of crisis (CPR, semi emergent procedures) and the night shift. In July 2008 an educational program was developed for nurses and physicians to identify effective communication behaviors and how to incorporate these communication behaviors into the clinical setting. Results: Data was collected prior to training from November 2006 until June 2008 which demonstrated compliance with the 16 behaviors identified. Behaviors were divided into four categories; coordination, awareness, cooperation, and communication. Prior to the initiation of the educational plan the audits demonstrated that CICU team members utilized effective communication strategies in 77% of opportunities in the category of coordination that includes verbalizing a plan and verbalizing expected timeframes. In the category of awareness, that includes evaluating the environment and verbalizing adjustments in the plan, techniques were observed in 83% of audited interactions. The category of cooperation, containing requests for external resources, asking for help from the team as needed, verbally requesting team input, cross monitoring, verbal assertion, and being receptive to assertion and ideas, occurred in 90% of exchanges. The final category of communication, containing closed loop, SBAR, thinking aloud, using names, communicating with the patient or parent, and appropriate tone of voice, was evident 88% of the time. The goal, set as an institutional baseline, is 90% compliance with all behaviors and a .10% improvement in any one element is considered significant improvement. Following this intervention, preliminary data demonstrates improvement in 15 out of the 16 communication techniques and only two behaviors, the use of names and use of the SBAR format, remain below the institutional standard of 90%. The use of names, which is below the institutional benchmark, has shown an 18% improvement in the compliance with this behavior. Conclusion: Clarity in communication and teamwork are important skills that a healthcare team must possess to increase reliability and decrease error and harm. Our data suggests that educational programs improve compliance around key communication skills.

Source: EMBASE

Full Text: Available in fulltext at EBSCO Host

25. Structured communication: improving patient safety with SBAR

Author(s): Dunsford J.

Citation: Nursing for women’s health, October 2009, vol./is. 13/5(384-390), 1751-486X (Oct 2009)

Publication Date: October 2009

Abstract: The Institute of Medicine (1999) has estimated that as many as 98,000 people die in U.S. hospitals each year due to preventable medical errors. The Joint Commission (2004) reports that 72 percent of root causes identified during the reviews of sentinel events related to infant death and injury during delivery are attributable to communication
failures. As a result, the Joint Commission (2008) has identified effective communication as one of its National Patient Safety Goals. Communication tools like SBAR (Situation, Background, Assessment and Recommendation) can help nurses focus communication to improve the effectiveness of information transfer. SBAR is especially important in urgent or high-acuity situations where clear and effective interpersonal communication is critical to patient outcomes.

Source: EMBASE

Full Text:
Available in fulltext at EBSCO Host

26. Hospitalist handoffs: A systematic review and task force recommendations

Author(s): Arora V.M., Manjarrez E., Dressler D.D., Basaviah P., Halasyamani L., Kripalani S.

Citation: Journal of Hospital Medicine, September 2009, vol./is. 4/7(433-440), 1553-5592;1553-5606 (September 2009)

Publication Date: September 2009

Abstract: BACKGROUND: Handoffs are ubiquitous to Hospital Medicine and are considered a vulnerable time for patient safety. PURPOSE: To develop recommendations for hospitalist handoffs during shift change and service change. DATA SOURCES: PubMed (through January 2007), Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network, white papers, and hand search of article bibliographies. STUDY SELECTION: Controlled studies evaluating interventions to improve in-hospital handoffs (n = 10). DATA EXTRACTION: Studies were abstracted for design, setting, target, outcomes (including patient-level, staff-level, or system-level outcomes), and relevance to hospitalists. DATA SYNTHESIS: Although there were no studies of hospitalist handoffs, the existing literature from related disciplines and expert opinion support the use of a verbal handoff supplemented with written documentation in a structured format or technology solution. Technology solutions were associated with a reduction in preventable adverse events, improved satisfaction with handoff quality, and improved provider identification. Nursing studies demonstrate that supplementing verbal exchange with a written medium leads to improved retention of information. White papers characterized effective verbal exchange, as focusing on ill patients and actions required, with time for questions and minimal interruptions. In addition, content should be updated daily to ensure communication of the latest clinical information. Using this literature, recommendations for hospitalist handoffs are presented with corresponding levels of evidence. Recommendations were reviewed by hospitalists at the Society of Hospital Medicine (SHM) Annual Meeting and by an interdisciplinary team of expert consultants and were endorsed by the SHM governing board. CONCLUSIONS: The systematic review and resulting recommendations provide hospitalists a starting point from which to improve in-hospital handoffs. 2009 Society of Hospital Medicine.

Source: EMBASE

27. Variation in the practice of emergency department handoffs

Author(s): Cheung D.S., Kelly J.J., Fuller D., McCullough L., Farley H., Dalsey W.

Citation: Annals of Emergency Medicine, September 2009, vol./is. 54/3 SUPPL. 1(S133-S134), 0196-0644 (September 2009)

Publication Date: September 2009

Abstract: Study Objectives: Although patient handoffs between providers at shift change in emergency departments (ED) are an important patient safety concern, little is known about its existing practice. We surveyed a representative sample of emergency physicians to assess the current state of ED handoffs. Methods: A focused nine question paper survey that queried emergency physicians about their practice of handoffs was distributed to all American College of Emergency Physician (ACEP) council members during the Scientific Assembly Council meeting held in October, 2008. Members of the council represented all 50 states and every type of hospital, eg, university, community, government, military and rural. The surveys were collected at the end of the session and manually entered into an
online electronic survey tool. Results: 250/304 responses were received to achieve a response rate of 82%. The majority of respondents (56%) indicated that they hand off on average less than 5 patients at shift change (8.8%, no patients; 12%, 5-10 patients; 18%, 10-20 patients; and 4.8%, >20 patients). In addition, 73% reported spending on average <=15 minutes on handoffs (5.5%, < 1 min; 32%, 1-5 min; 36%, 5-15 min; 25%, 15-30 min; 2%, >30 min). 50% of respondents indicated that they usually perform handoffs at a provider or nursing station, while 18% use a white board most commonly, and 13% perform handoffs primarily at the bedside. On a five-point Likert scale ranging from 1 (not satisfied) to 5 (completely satisfied), respondents rated the overall quality of their ED handoff practices a mean of 3.4 (95% CI: 3.3-3.5). Emergency physicians also reported varying percentages of shifts in which they experience deficient handoffs (25% reported <5% deficient, 34%, 5-10% deficient; 26%, 10-25% deficient; 12%, 25-50% deficient; 3.7%, >50% deficient). However, 82% felt this resulted in harm to patients less than 5% of the time. The most common deficiencies cited were incomplete information, eg, history, exam finding or lab/radiology result; and inaccurate or vague working diagnoses (both were cited by 60% of respondents). 35% of respondents said that a primary deficiency of their handoffs was completely forgetting to sign out a patient in the ED. Considerable differences in the frequency with which emergency physicians visits patients at bedside after the handoff also exist (0.8%, never; 10%, rarely; 33%, sometimes; 38%, usually; 18%, always). Conclusion: The current state of emergency physician to physician handoffs at change of shift displays tremendous heterogeneity in practice with regards to the number of patients handed off, the location of these handoffs and the time spent to accomplish this critical task. The mean satisfaction score of emergency physicians with their current handoff process suggests room for improvement.

Source: EMBASE

Full Text:
Available in fulltext at Ovid
Available in print at Pilgrim Hospital Staff Library

28. The content and context of change of shift report on medical and surgical units.

Author(s): Staggers N, Jennings BM
Citation: Journal of Nursing Administration, 01 September 2009, vol./is. 39/9(393-398), 00020443
Publication Date: 01 September 2009
Abstract: OBJECTIVE: This study was conducted to describe the current content and context of change of shift report (CoSR) on medical and surgical units and explore whether nurses use computerized support during the CoSR process. BACKGROUND: Change of shift report is a commonly occurring handoff that could contribute to gaps in care. METHODS: Bedside, face-to-face, and audiotaped CoSRs were audiotaped and observed on 7 medical and surgical units in 3 acute care facilities in the Western United States. RESULTS: Conventional content analysis revealed 4 themes: the Dance of Report, Just the Facts, Professional Nursing Practice, and Lightening the Load. Observations exposed the lack of content structure, high noise levels, interruptions, and no use of electronic health records in these facilities as a part of the report process. CONCLUSION: Improvements to CoSR include determining a consistent and tailored structure for report, evaluating types of report suitable for particular units, reducing interruptions and noise, and determining content amenable to computerization.

Source: CINAHL

29. The implementation process of a communication tool for all health care staff: Situation, background, assessment, recommendation

Author(s): Hansen I.
Citation: Quality and Safety in Health Care, August 2009, vol./is. 18/4(e1), 1475-3898 (August 2009)
Publication Date: August 2009
Problem: Transformation problems of a concise patient report between staff are well known. Poor reports are harmful, reduce patient safety and elevate stress levels. Incidents lead to adverse event reports and elevated need of root cause analysis. Strategy: The implementation of situation, background, assessment, recommendation (SBAR) started in Hoglandet Health Care Area (Jonkoping County, Sweden). The tool was demonstrated at a regional chief meeting. Information series started which included the SBAR tool addressed towards groups of doctors, nursing personal and the managing board. Four primary care districts and eight hospital departments learned about SBAR; doctors and nurses had priority. Demonstration of the tool for doctors gave very positive reactions facilitating the implementation process. Several departments would like to start using the tool at once but we need a check of quality first. One internal medicine ward tested one version during May 2008 and a pocket card in August. Next we made simulated reporting between different professionals for correct use of SBAR. With the use of interviews, the chief of an internal medicine ward measured demands and specific terms of assessment. Improvement/Changes: The nurse staff felt very good using the SBAR, especially younger members. This was surprising compared with experience from other improvement work. From the interviews: I feel safe when I report because I know that the risk for missing important information decreases, I feel safe when I contact the doctor on duty because I am well informed, I report present data and what is relevant in a structured fashion, my own information about the patient increased. Conclusion: Lessons learnt so far are positive. SBAR is easy to use and the concept seems easy to sell to doctors, nurses and managing leaders. The pocket card format is convenient to users.

Source: EMBASE

30. The SBAR communication technique: teaching nursing students professional communication skills.

Author(s): Thomas CM, Bertram E, Johnson D
Citation: Nurse Educator, 01 July 2009, vol./is. 34/4(176-180), 03633624
Publication Date: 01 July 2009
Abstract: The Joint Commission and Institute for Healthcare Improvement have mandated healthcare organizations to improve professional communication. Nursing students lack experience in communicating with physicians. As a result, recent graduates may not be prepared to meet the demands of professional communication to ensure patient safety. The authors discuss the SBAR (situation, background, assessment, recommendations) communication technique implemented during a 2-day simulation exercise that provided an organized logical sequence and improved communication and prepared graduates for transition to clinical practice.

Source: CINAHL

31. Handovers by the board.

Citation: Nursing Management - UK, 01 June 2009, vol./is. 16/3(4-), 13545760
Publication Date: 01 June 2009
Abstract: The article reports that a patient handover system implemented by the James Cook University Hospital has saved nurses five hours a week. A white board is used instead of paper based notes to collate patient information. The system, which was introduced as part of the Productive Ward programme of Great Britain's Department of Health, allows nurses to spend more time with patients.

Source: HEALTH BUSINESS ELITE

Full Text:
Available in fulltext at EBSCO Host
Available in fulltext at EBSCO Host

32. Uni- and interdisciplinary effects on round and handover content in intensive care units

Author(s): Miller A., Scheinkestel C., Limpus A., Joseph M., Karnik A., Venkatesh B.
Objective: The aim of this study was to explore differences in the verbal content of handovers and rounds conducted in uni- and interdisciplinary social contexts. We expected higher proportions of goals to be articulated during interdisciplinary rounds.

Background: Lack of explanatory connections between round improvement initiatives and outcomes suggest insufficient understanding about health care communications, especially the role of social interaction. Methods: The recognition-primed abstract decomposition space (RP-ADS) was used to analyze the information content of nurse handovers and morning rounds in a unidisciplinary- (physicians only) and an interdisciplinary-round intensive care unit (ICU). Data were collected using audio recordings of rounds and handovers for five patients for 5 days each in both ICUs. Results: Hierarchical log-linear analyses show strong associations between events (medical rounds vs. nurses’ shift handovers), type (uni- vs. interdisciplinary), and focus (levels of the RP-ADS) with highly significant combined two-way and higher-order interactions, LRchi²(df = 4) = 30.91, p <.0001. All tests of partial association were also highly significant. Differences among levels of the variables were evaluated using standardized residuals. Conclusion: Nurses focused on RP-ADS data and intervention levels, whereas physicians focused on diagnoses and expectations. Clinical goals that integrate these orientations emerged to a greater extent in interdisciplinary rounds. In addition, social context of rounds appears to influence nurse handovers. Unidisciplinary ICU nurse handovers consisted of a series of data-and intervention-related observations, whereas ICU nurse handovers in interdisciplinary ICUs tended to integrate data, interventions and clinical goals. Application: These results are relevant to the design and implementation of clinical communication improvement initiatives and support tools. Copyright 2009, Human Factors and Ergonomics Society.

Author(s): Clark E., Squire S., Heyme A., Mickle M.E., Petrie E.
improving shift-to-shift clinical handover

Author(s): Yee K.C., Wong M.C., Turner P.

Citation: The Medical journal of Australia, June 2009, vol./is. 190/11 Suppl(S121-124), 0025-729X (1 Jun 2009)

Publication Date: June 2009

Abstract: OBJECTIVE: To develop, using an evidence-based approach, a standardised operating protocol (SOP) and minimum dataset (MDS) to improve shift-to-shift clinical handover by medical and nursing staff in a hospital setting. DESIGN, SETTING AND PARTICIPANTS: A pilot study conducted in six clinical areas (nursing and medical handovers in general medicine, general surgery and emergency medicine) at the Royal Hobart Hospital between 1 October 2005 and 30 September 2008. Data collection and analysis involved triangulation of qualitative techniques; 120 observation sessions and 112 interviews involving nurses and junior medical officers were conducted across the six clinical areas; information on more than 1000 individual patient handovers was analysed. RESULTS: We developed an overarching four-step SOP and MDS for clinical handover, summarised by the acronym "HAND ME AN ISOBAR". This standardised solution supports flexible adaptation to local circumstances. CONCLUSION: A standardised protocol for clinical handover can be developed and validated across professional and disciplinary boundaries. It is anticipated that our model will be transferable to other sites and clinical settings.

Source: EMBASE

35. Bedside handover: quality improvement strategy to "transform care at the bedside"

Author(s): Chaboyer W, McMurray A, Johnson J, Hardy L, Wallis M, Chu FY

Citation: Journal of Nursing Care Quality, 01 April 2009, vol./is. 24/2(136-142), 10573631

Publication Date: 01 April 2009

Abstract: This quality improvement project implemented bedside handover in nursing. Using Lewin's 3-Step Model for Change, 3 wards in an Australian hospital changed from verbal reporting in an isolated room to bedside handover. Practice guidelines and a competency standard were developed. The change was received positively by both staff and patients. Staff members reported that bedside handover improved safety, efficiency, teamwork, and the level of support from senior staff members.

Source: CINAHL

36. Identifying key nursing and team behaviours to achieve high reliability

Author(s): MILLER K, RILEY W, DAVIS S

Citation: Journal of Nursing Management, 01 March 2009, vol./is. 17/2(247-255), 09660429

Publication Date: 01 March 2009

Abstract: Aim The aim of the present study was to measure markers of key nursing behaviours in interdisciplinary teams during critical events to assess the extent of high reliability. Background Technical and team competence are necessary to achieve high reliability to ensure safe patient care. Technical competence is generally assured because of professional training, licensure and practice standards. During critical events, team competence is difficult to observe, measure and evaluate in interdisciplinary teams. Method During critical events, in situ simulation was the method used to observe interdisciplinary interaction of nursing behaviours regarding communication. Seventeen trials were conducted and videotaped for evaluation at four hospital sites. Results Key nursing behavioural markers for interdisciplinary interaction were described: situational awareness, use of situation, background, assessment, recommendation-response (SBAR-R), closed-loop communication and shared mental model. Conclusion Skills necessary for nurses to contribute to highly reliable, interdisciplinary teams are not consistently observed during critical events and constitute breaches in defensive barriers for ensuring patient safety. Implications for nursing management Nurses have a key role in assuring effective team
performance through the transfer of critical information. Nurses need to recognize and identify important clinical and environmental cues, and act in order to ensure that the team progresses along the optimal course for patient safety.

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host

37. Talking about patients: nurses' language use during hand-offs.

Author(s): Ford YB
Citation: , 01 January 2009, vol./is. /(0-255),
Publication Date: 01 January 2009

Abstract: Miscommunication during end of shift hand-offs between hospital nurses has been implicated as a source of errors in patient care, yet little research evaluates the structure of language during communication in an attempt to understand potential communication errors. Although the functions and meaning of hand-offs for nurses has previously been examined, there is little information about the current state of the structure and language of hand-offs. This research begins to fill that gap in by using genre analysis of transcripts of 43 end-of-shift hand-offs between nurses at four hospitals in the Midwestern United States.

Source: CINAHL

38. A standard operating protocol (SOP) and minimum data set (MDS) for nursing and medical handover: considerations for flexible standardization in developing electronic tools

Author(s): Turner P., Wong M.C., Yee K.C.
Citation: Studies in health technology and informatics, 2009, vol./is. 143/(501-506), 0926-9630 (2009)
Publication Date: 2009

Abstract: As part of Australia's participation in the World Health Organization, the Australian Commission on Safety and Quality in Health Care (ACSQHC) is the leading federal government technical agency involved in the area of clinical handover improvement. The ACSQHC has funded a range of handover improvement projects in Australia including one at the Royal Hobart Hospital (RHH), Tasmania. The RHH project aims to investigate the potential for generalizable and transferable clinical handover solutions throughout the medical and nursing disciplines. More specifically, this project produced an over-arching minimum data set (MDS) and over-arching standardized operating protocol (SOP) based on research work on nursing and medical shift-to-shift clinical handover in general medicine, general surgery and emergency medicine. The over-arching MDS consists of five headings: situational awareness, patient identification, history and information, responsibility and tasks and accountability. The over-arching SOP has five phases: preparation; design; implementation; evaluation; and maintenance. This paper provides an overview of the project and the approach taken. It considers the implications of these standardized operating protocols and minimum data sets for developing electronic clinical handover support tools. Significantly, the paper highlights a human-centred design approach that actively involves medical and nursing staff in data collection, analysis, interpretation, and systems design. This approach reveals the dangers of info-centrism when considering electronic tools, as information emerges as the only factor amongst many others that influence the efficiency and effectiveness of clinical handover.

Source: EMBASE

Full Text:
Available in fulltext at EBSCO Host

39. Improved record-keeping with reading handovers

Author(s): Tucker, Alison
Nursing handover has traditionally been performed orally and apart from patients. Results of an audit undertaken at the Royal United Hospital, Bath, suggest that record-keeping standards there were poor. To improve these standards, a method of ‘reading handover’, in which the main method of communication between nurses on different shifts is written rather than oral, was introduced on one ward. This article discusses the results of this pilot study and suggests that the new handover method has improved standards of record keeping. Cites 16 references. [Journal abstract]

Citation: Nursing Management, 2009, vol./is. 16/8, 1354-5760
Publication Date: 2009

The teaching of a structured tool improves the clarity and content of interprofessional clinical communication.

Author(s): Marshall, S., Flanagan, B., Harrison, J.
Citation: Quality and Safety in Health Care, 2009, vol./is. 18/2(137-140), 1475-3898
Publication Date: 2009

Purpose: To investigate the effects of a fully functional electronic patient record (EPR) system on clinicians' work during team conferences, ward rounds, and nursing handovers. Method: In collaboration with clinicians an EPR system was configured for a stroke unit and in trial use for 5 days, 24 h a day. During the trial period the EPR system was used by all clinicians at the stroke unit and it replaced all paper records. The EPR
system simulated a fully integrated clinical-process EPR where the clinicians experienced the system as if all transactions were IT supported. Such systems are not to be expected to be in operational use in Denmark until at least 2 years from now. The EPR system was evaluated with respect to its effects on clinicians’ mental workload, overview, and need for exchanging information. Effects were measured by comparing the use of electronic records with the use of paper records prior to the trial period. The data comprise measurements from 11 team conferences, 7 ward rounds, and 10 nursing handovers. Results: During team conferences the clinicians experienced a reduction on five of six subscales of mental workload, and the physicians experienced an overall reduction in mental workload. The physician in charge also experienced increased clarity about the importance of and responsibilities for work tasks, and reduced mental workload during ward rounds. During nursing handovers the nurses experienced fewer missing pieces of information and fewer messages to pass on after the handover. Further, the status of the nursing plans for each patient was clearer for all nurses at the nursing handovers except the nurse team leader, who experienced less clarity about the status of the plans. Conclusion: The clinicians experienced positive effects of electronic records over paper records for the three clinical activities involved in the evaluation. This is important in its own right and likely to affect clinicians’ acceptance of EPR systems, their command of their work, and consequently the attainment of ‘downstream’ effects on patient outcomes. 2008 Elsevier Ireland Ltd. All rights reserved.

Source: EMBASE

42. Supporting families through discharge from PICU to the ward: the development and evaluation of a discharge information brochure for families.

Author(s): Linton S, Grant C, Pellegrini J

Citation: Intensive & Critical Care Nursing, 01 December 2008, vol./is. 24/6(329-337), 09643397

Publication Date: 01 December 2008

Abstract: INTRODUCTION: Discharge from paediatric ICU and transfer to the ward can evoke fear and anxiety. Along with the introduction of the ICU liaison nurse role, the literature suggests that the provision of written information has the greatest potential to reduce transfer anxiety. This paper will discuss the issues associated with discharge from a paediatric ICU, the process of identifying the information needs of families, the development of a written brochure and evaluation of the brochure in practice. RESULTS: Evaluation of the ‘discharge from ICU’ brochure found, 95% of parents believed the brochure was easy to read, understand and helpful in improving their understanding of what to expect on the ward. 95% also found it useful to have the transfer ward details written down prior to leaving the PICU. 85% agreed the brochure helped to answer their questions in relation to the transfer. CONCLUSION: The introduction of a brochure explaining the process of discharge from ICU and what to expect on the wards received positive feedback from families. The brochure provides families with generic information regarding ICU transfer, however, it is important for the ICU liaison nurse to promote discussion and tailor the information for the particular experiences and needs of each patient and family situation.

Source: CINAHL

Full Text:
Available in print at Lincoln County Hospital Professional Library

43. Simple Standardized Patient Handoff System that Increases Accuracy and Completeness

Author(s): Wayne J.D., Tyagi R., Reinhardt G., Rooney D., Makoul G., Chopra S., DaRosa D.A.

Citation: Journal of Surgical Education, November 2008, vol./is. 65/6(476-485), 1931-7204 (November 2008/December 2008)

Publication Date: November 2008

Abstract: Purpose: The Joint Commission on Accreditation of Healthcare Organizations
(JCAHO) defines a "handoff" as a contemporaneous, interactive process of passing patient-specific information from one caregiver to another for the purpose of ensuring the continuity and safety of patient care. The purpose of this study was to conduct a comprehensive investigation on the determinants of an effective handoff management system. Specifically, we sought to address the following null hypotheses: There is no difference before and after implementation of a new, low-cost, low-tech process for surgery patient handoffs in accuracy of information, completeness, clarity of exact time of patient transfer, and number of tasks appropriately handed off. Methods: Baseline description of the handoff process was mapped from 3 direct observation sessions by an efficiency operations team. A focus group with residents, nurses, hospital administrators, and surgeons was held to identify concerns with the baseline process and to identify important features of a handoff system. These data were used to create an electronic survey for residents to indicate level of agreement with importance of various features and qualities of a handoff system. Longitudinal telephone surveys were performed with residents throughout and after the development period to determine the residents' perceptions of the completeness, accuracy, clarity of handoff time, and method of information transfer, as well as the frequency with which residents were expected to perform tasks that should have been performed by outgoing residents. An online survey was sent to residents before and after the new handoff system was implemented to study perceptions of information quality, process operations, clarity of responsibility, and satisfaction with the handoff process. Perceptions were rated on operationally defined scales. All instruments underwent expert review for content validity and clarity of instructions and scale definition appropriateness. A standardized, and partially automated, handoff form was then developed. After a 2-week pilot study, telephone surveys were repeated. Data were analyzed using descriptive statistics, the Student t-test, and multivariate analysis. Results: Compared with baseline, residents reported increased accuracy, as measured by the perceived number of inaccuracies found on sign-out sheets (p = 0.003). Completeness of the information on sign-out sheets also was improved (p = 0.015). Clarity as to the time of transfer of care from outgoing (day team) to incoming (night float) improved (p = 0.0001). The type of rotation (intensive care unit vs non-intensive care unit) did lead to an improvement (confidence interval< 99%). Across both shifts, the perceived number of inappropriate tasks transferred decreased significantly. Experience (months of training) and type of rotation did not affect these measures. Conclusions: By simplifying and standardizing the handoff instrument, we demonstrated improvements in resident perceptions of accuracy, completeness, and number of tasks transferred. This low-cost, low-tech paradigm may be useful to others. 2008 Association of Program Directors in Surgery.

Source: EMBASE

44. An effort to discontinue the use of verbal change of shift reports in a workplace with both nursing staff and personal support workers--encouraging independent information collection by personal support workers

Author(s): Kawabata E., Norioka T., Kisida M., Nomura M.

Citation: Nihon Hansenbyo Gakkai zasshi = Japanese journal of leprosy : official organ of the Japanese Leprosy Association, September 2008, vol./is. 77/3(225-230), 1342-3681 (Sep 2008)

Publication Date: September 2008

Abstract: The change of shift report is of great importance in nursing in order to ensure the continuity of care, transfer information among nurses, and to ensure the transfer of responsibility from one shift to the next. In workplaces where nursing staff work together with personal support workers, it is important for staff to have common access to patient information in order to be able to use the information practically and carry out their individual responsibilities and roles. Until now, nursing staff and personal support workers collaborated and combined information for the verbal change of shift report, but the role of the personal support worker was in practice, more passive. Beginning 3 years ago, nurses began planning training sessions to educate personal support workers to increase their practical abilities. Through the training, personal support workers learned how to leave accurate patient records and nursing staff and personal support worker staff began to use a joint flow sheet to keep a record of patient information. This written record became the means of communication, making the verbal change of shift report redundant. As a result of trying to discontinue the verbal change of shift reports, personal support workers began to
collect information more independently, and began to practice care more intentionally. In addition, the understanding of the role of the personal support worker deepened, the ability to care for patients improved, and it also led to better cooperation between nursing staff and personal support workers.

Source: EMBASE


Author(s): Sharit, Joseph, McCane, Lorgia, Thevenin, Deborah M., Barach, Paul

Citation: Risk Analysis: An International Journal, 01 August 2008, vol./is. 28/4(969-981), 02724332

Publication Date: 01 August 2008

Abstract: This article reports on a qualitative study that investigated how various risk factors associated with the process of sign-out reporting across shifts in critical care hospital environments could lead to flawed communication and thus to increased risk of poor patient outcomes. The study was performed in two critical care hospital units: the pediatric intensive care unit (PICU) and the postanesthesia care unit (PACU). We collected data from observations of eight nurses and four resident physicians in the PICU and four nurses and four resident physicians in the PACU giving sign-out reports during their shift changes. In addition, we conducted semi-structured interviews with a separate sample of medical providers consisting of nurse managers, attending physicians, nurses, and residents from each of these two units. The issues that were addressed in these interviews included how various methods of conducting sign-outs and factors such as personality and experience could impact the effectiveness of communication during sign-out reporting. We also collected data from these medical providers on how failures in communication during sign-out reporting could lead to potentially adverse patient outcomes. The article concludes with the presentation of a modeling framework that demonstrates how the combined influences of risk factors can generate a particularly important type of failure mode in communication and how interventions can be targeted to serve as barriers to such events. A number of recommendations intended for reducing risks associated with the communication of sign-out reports are also presented.

Source: HEALTH BUSINESS ELITE

Full Text:
Available in fulltext at EBSCO Host
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46. Nursing handover: it's time for a change.

Author(s): O'Connell B, Macdonald K, Kelly C

Citation: Contemporary Nurse: A Journal for the Australian Nursing Profession, 01 August 2008, vol./is. 30/1(2-11), 10376178

Publication Date: 01 August 2008

Abstract: Nursing handover is a common part of nursing practice that is fundamental to safe patient care. Despite this, the literature provides little direction on the best way to conduct handover. This project aimed to examine nurses' perceptions of handover and to determine the strengths and limitations of the handover process. A staff survey was distributed to nurses in all inpatient wards at a metropolitan tertiary hospital. A total of 176 nurses responded to the staff survey. The findings revealed conflicting opinions about the effectiveness of the handover process; although a number of nurses were positive about current handover practice, indicating they were provided with sufficient information about patients and given opportunity to clarify patient care information, other nurses identified aspects of handover that could be improved. These included: the subjectivity of handover information, the time taken to conduct handover, repetition of information that could be found in the patients' care plans, and handing over of information by a nurse who has not cared for the patient. Some attention needs to be given to addressing the perceived weaknesses associated with the handover process.
47. Improving handoff communications in critical care: utilizing simulation-based training toward process improvement in managing patient risk.

Author(s): Berkenstadt H, Haviv Y, Tuval A, Shemesh Y, Megrill A, Perry A, Rubin O, Ziv A

Citation: CHEST, 01 July 2008, vol./is. 134/1(158-162), 00123692
Publication Date: 01 July 2008

Abstract: BACKGROUND: A patient admitted to the medical step-down unit experienced severe hypoglycemia due to an infusion of a higher-than-ordered insulin dose. The event could have been prevented if the insulin syringe pump was checked during the nursing shift handoff. METHODS: Risk management exploration included direct observations of nursing shift handoffs, which highlighted common deficiencies in the process. This led to the development and implementation of a handoff protocol and the incorporation of handoff training into a simulation-based teamwork and communication workshop. A second round of observations took place 6 to 8 weeks following training. RESULTS: The intervention demonstrated an increase in the incidence of nurses communicating crucial information during handoffs, including patient name, events that had occurred during the previous shift, and treatment goals for the next shift. However, there was no change in the incidence of checking the monitor alarms and the mechanical ventilator. CONCLUSIONS: Simulation-based training can be incorporated into the risk management process and can contribute to patient safety practice.

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host

48. Shift handover from nurses’ perspective.

Citation: Revista Paulista de Enfermagem, 01 April 2008, vol./is. 27/2(0-0), 01008889
Publication Date: 01 April 2008

Abstract: This study analyzed the point of view of the nursing team members during the shift handover as well as factors which interfere in communication. An exploratory study by means of a questionnaire and free observation was carried out. The results evinced that nursing professionals consider handoff of shifts important in care, administration and education and should include occurrences and patient treatment. Haste in leaving or delay in handoff and external interferences such as noises, ringing of phones as well as parallel conversations were pointed out as factors which interfere in communication. It was concluded that shift handoff is important in the continuity of nursing care, although there are interferences in the group of internal and external factors.

Source: CINAHL

49. Effectiveness of an Adapted SBAR Communication Tool for a Rehabilitation Setting

Author(s): Velji K., Baker G.R., Fancott C., Andreoli A., Boaro N., Tardif G., Aimone E., Sinclair L.

Citation: Healthcare quarterly (Toronto, Ont.), 2008, vol./is. 11/3 Spec No.(72-79), 1710-2774 (2008)
Abstract: Effective communication and teamwork have been identified in the literature as key enablers of patient safety. The SBAR (Situation-Background-Assessment-Recommendation) process has proven to be an effective communication tool in acute care settings to structure high-urgency communications, particularly between physicians and nurses; however, little is known of its effectiveness in other settings. This study evaluated the effectiveness of an adapted SBAR tool for both urgent and non-urgent situations within a rehabilitation setting. In phase 1 of this study, clinical staff, patient and family input was gathered in a focus-group format to help guide, validate and refine adaptations to the SBAR tool. In phase 2, the adapted SBAR was implemented in one interprofessional team; clinical and support staff participated in educational workshops with experiential learning to enhance their proficiency in using the SBAR process. Key champions reinforced its use within the team. In phase 3, evaluation of the effectiveness of the adapted SBAR tool focused on three main areas: staff perceptions of team communication and patient safety culture (as measured by the Agency for Healthcare Research and Quality Hospital Survey on Patient Safety Culture), patient satisfaction (as determined using the Client Perspectives on Rehabilitation Services questionnaire) and safety reporting (including incident and near-miss reporting). Findings from this study suggest that staff found the use of the adapted SBAR tool helpful in both individual and team communications, which ultimately affected perceived changes in the safety culture of the study team. There was a positive but not significant impact on patient satisfaction, likely due to a ceiling effect. Improvements were also seen in safety reporting of incidents and near misses across the organization and within the study team.

Source: EMBASE

50. Nurses' perception of shift handovers in Europe - results from the European Nurses' Early Exit Study.

Author(s): Meissner A, Hasselhorn H, Estryn-Behar M, Nezet O, Pokorski J, Gould D

Citation: Journal of Advanced Nursing, 01 March 2007, vol./is. 57/5(535-542), 03092402

Abstract: Aim. This paper reports a study exploring nurses' perceptions of the shift handover and the possible reasons for reported dissatisfaction in 10 European countries. Background. The nursing handover fulfills a number of purposes and has important consequences for the continuity of patient care and nurses' satisfaction with the quality of care they are able to provide. However, the performance and function of shift handovers in health care is a widely neglected topic in practice and research. Method. The Nurses' Early Exit Study (http://www.next-study.net) investigates the working conditions of nurses and variables influencing nursing retention. The data for this analysis were collected between 2002 and 2003 by self-report questionnaires in 10 European countries. Findings. The percentage of nurses dissatisfied with shift handovers ranged from 22% in England to 61% in France. In most countries the main reason for dissatisfaction with shift handovers was 'too many disturbances', followed by 'lack of time'. Most countries showed similar associations of dissatisfaction with qualification level and occupational seniority, but not with position and type of shift. 'Poor quality of leadership' and 'poor support from colleagues', were strongly associated with dissatisfaction. Conclusions. In several (but not all) European countries, shift handovers may be a frequent cause for nurses' irritation. The underlying causes appear to be of an organizational nature. The findings have implications for solutions. Further debate and research should clarify the different purposes of shift handovers and relate them to handover style and to the quality of patient care.

Source: CINAHL

Full Text: Available in fulltext at Ovid
Available in fulltext at EBSCO Host

51. The evolution of nurse-to-nurse bedside report on a medical-surgical cardiology unit
Author(s): Caruso E.M.

Citation: Medsurg nursing : official journal of the Academy of Medical-Surgical Nurses, February 2007, vol./is. 16/1(17-22), 1092-0811 (Feb 2007)

Publication Date: February 2007

Abstract: Change of shift report is unique to the nursing profession. During report, nurses transfer critical information to promote patient safety and best practices. Nurse-to-nurse bedside report is described as a strategy that includes the patient in the reporting process and is an innovative alternative to traditional shift report.

Source: EMBASE

Full Text:
Available in fulltext at EBSO Host

52. Developing a guide to improve the quality of nurses’ handover.

Author(s): Fenton W

Citation: Nursing Older People, 01 December 2006, vol./is. 18/11(32-36), 14720795

Publication Date: 01 December 2006

Abstract: This article considers the importance of handover as a means of communicating important patient information from one nursing shift to the next. It describes the development of a guide, based on Essence of Care benchmarks, intended to improve the quality of nursing handover. A post implementation audit suggests that once staff were familiar with the guide, handovers became more structured and informative.

Source: CINAHL

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Available in print at Lincoln County Hospital Professional Library
Available in print at Pilgrim Hospital Staff Library

53. Transfer of accountability: transforming shift handover to enhance patient safety

Author(s): Alvarado K., Lee R., Christoffersen E., Fram N., Boblin S., Poole N., Lucas J., Forsyth S.

Citation: Healthcare quarterly (Toronto, Ont.), October 2006, vol./is. 9 Spec No/(75-79), 1710-2774 (Oct 2006)

Publication Date: October 2006

Abstract: Communication of information between healthcare providers is a fundamental component of patient care. The information shared between providers who are changing shifts, referred to as "handover," helps plan patient care, identifies safety concerns and facilitates continuity of information. Absent or inaccurate information can have deleterious effects on patient care. According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO 2003), almost 70% of all sentinel events are caused by breakdown in communication. Issues and concerns regarding the effectiveness of handover at shift change were raised by nurses throughout Hamilton Health Sciences (HHS), leading to the approval of a hospital-wide project to implement evidenced-based Transfer of Accountability (TOA) Guidelines and a bedside patient safety checklist. This article describes the development of the guidelines, the results of the pilot study and the ongoing implementation of the project. The observed impact on patient safety within HHS is presented.

Source: EMBASE

54. ‘Handing over’: transmission of information between nurses in an intensive
therapy unit.

Author(s): Philpin S

Citation: Nursing in Critical Care, 01 March 2006, vol./is. 11/2(86-93), 13621017

Publication Date: 01 March 2006

Abstract: Transferring end of shift information between nurses via both verbal and written routes in an intensive therapy unit (ITU) setting is complex and multifaceted. Some authors have taken ethnographic approaches and explored the verbal handover as an example of a nursing ritual. The written route involves various textual materials, which, in addition to conveying essential information about the patient's status, also represent other messages. This article considers two key areas of end of shift information transmission - verbal bedside handovers and written accounts - arguing that in addition to the manifest purposes of transferring essential information between nurses, both modes of reporting also have important latent functions. It will explore and interpret elements of ritual and symbolism inherent in both forms of handover. The article reports on particular findings from a larger ethnographic study of nursing culture, which was accomplished through participant observation over a 12-month period in ITU. Subsidiary components of the ethnography were the interviews with 15 nurses and the examination of documentary material. The findings suggest that both verbal and written reports, in addition to ensuring that nurses taking over the care of the patient receive the necessary information to enable them to safely provide continuity of care, also convey essential meanings and articulate group values. Both modes of handover reporting are also visual and/ or audible symbolic representations of nursing care in ITU and as such confirm and validate that care, expressing the value of nursing work in this unit.

Source: CINAHL

Full Text:
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55. HANDS: A revitalized technology supported care planning method to improve nursing handoffs

Author(s): Keenan G., Yakel E., Marriott D.

Citation: Studies in health technology and informatics, 2006, vol./is. 122/(580-584), 0926-9630 (2006)

Publication Date: 2006

Abstract: Care plans are required by the Joint Commission on Accreditation of Healthcare Organizations. Each day nurses create and file these plans in medical records. However, current forms of care plans do little to either enhance the flow of information or communicate shared patient goals. This paper introduces the theoretical model underpinning the HANDS care planning method and presents findings on the first year of a 3-year multisite study in which this method and a new Health Information Technology (HIT) application supporting the process were introduced. The theoretical model is derived from research on high reliability organizations and encompasses collective mind, mindfulness, and heedful interrelating. It focuses on the handoff as a focal point for not only information transfer but also reinforcing shared meaning and goals. The specific application, HANDS, integrates the NANDA, NIC, and NOC terminologies as a means of ensuring shared meaning across shifts and units. Early findings show the method has the potential of revolutionizing nursing practice.

Source: EMBASE

Full Text:
Available in fulltext at EBSCO Host
Abstract: BACKGROUND: Communication problems among health care workers are a common, preventable source of hospital-related morbidity and mortality. Internal medicine residents at Jacobi Medical Center (Bronx, NY) began using an electronic sign-out program that had been incorporated into the computerized medical record. This new system had been developed to improve the quality of information transfer between cross-covering residents. Eighteen months later, a pilot study was initiated to explore the potential benefits of offering inpatient nurses access to this sign-out data.

METHODS: Nursing staff members were provided electronic access to the residents' sign-out information. Nurses received printouts of the computerized sign-outs at the start of each shift and were asked to use the sign-out program as a basis for their care plans and nursing change-of-shift "report." 

RESULTS: The 19 (of 20) nurses who completed the survey agreed that using the resident sign-out program positively affected their ability to care for their patients. In addition, the intervention improved nurses' understanding of the patients' reason for admission, helped to improve communication between physicians and nurses, and raised nursing morale.

DISCUSSION: Incorporation of a housestaff electronic sign-out system into nursing daily workflow demonstrated multiple benefits and facilitated the transfer of valuable patient information from housestaff to nurses.

Source: MEDLINE

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57. Measurement of the clinical usability of a configurable EHR.

Abstract: The objective of the project was to measure the clinical usability of an EHR configured by use of participatory design with clinicians from a neurological stroke unit in order to get input to the County's future strategy for incremental implementation of EHR. The content of the EHR was defined during a series of workshops with the clinicians after which the XML configuration files were written and deployed. In parallel with this, the participants from the University identified, prioritised and further specified a number of effects related to the clinical practice to be measured. The effects requested by the clinicians focused on improving their overview and assessment of patients as well as on more efficient coordination in three specific and highly cooperative situations, viz. nursing handover, ward round and patient conference. All three situations were measured before (using paper-based medical records) as well as during the week where the configured EHR completely replaced the paper-based medical record in order to compare a 'before' and 'after' situation. Measurements were focused on the requested effects and acquired using various techniques including questionnaires, interviews, observations, and Task Load Index (TLX) ratings. In total, 15 nursing handovers, 8 ward rounds, and 11 patient conferences involving a total of 35 patients and more than 20 clinicians were included in the measurements. Data from the project has been comparatively analysed by means of the TLX scores. Our results show several significant results, for example, during ward rounds the physicians experienced a significant improvement of TLX. The experiment has proven it possible to configure the content of an EHR that significantly improves the clinician's overview of the patient's current status in different clinical situations during the clinical process, based on the clinician's actual needs. Furthermore, the configuration process gave the County valuable experience concerning the content and management of a participatory design process as well as documentation of utility value that will be incorporated in future EHR projects.

Source: MEDLINE

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Full Text:
58. Improving transfer from the intensive care unit: the development, implementation and evaluation of a brochure based on Knowles' Adult Learning Theory.

Author(s): Mitchell ML, Courtney M

Citation: International Journal of Nursing Practice, 01 December 2005, vol./is. 11/6(257-268), 13227114

Publication Date: 01 December 2005

Abstract: This paper describes the development, implementation and evaluation of a transfer brochure for family members of patients in an intensive care unit (ICU) to improve patient transfer to a general ward. When family members fail to understand information, they respond in ways that affect patient recovery. The brochure was designed within Knowles' Adult Learning Theory framework and developed using a multidisciplinary team. A mixed design was used to collect data from families and nurses. Results indicate that the brochure helped nurses to address the individual family's issues during transfer from ICU. Furthermore, 95% of nurses (n = 33) recommended its introduction for all future transfers. Family members (n = 82) who received the brochure as part of their transfer were significantly more satisfied with all aspects of transfer than those who experienced ad hoc transfer methods (n = 80). These results provide strong support for Knowles' Adult Learning Theory as an educational foundation for adult learning.

Source: CINAHL

59. Handover. Pilot study to show the loss of important data in nursing handover.

Author(s): Pothier D, Monteiro P, Mooktiar M, Shaw A

Citation: British Journal of Nursing (BJN), 10 November 2005, vol./is. 14/20(1090-1093), 09660461

Publication Date: 10 November 2005

Abstract: A good nursing handover process is a crucial part of providing quality nursing care in a modern healthcare environment. The conservation of patient data during the handover process is vital to ensure good continuity of care and safe practice. Any errors or omissions made during the handover process may have dangerous consequences. The authors observed the handover of 12 simulated patients over five consecutive handover cycles between nurses. Three handover styles were used and the amount of data loss was recorded for each style. A purely verbal handover style resulted in the loss of all data after three cycles. A note-taking style (the traditional style used in most hospital wards) resulted in only 31% of data being transferred correctly after five cycles. When a typed sheet was included with the verbal handover, data loss was minimal. Current handover methods may result in significant loss of important data that may impact on patient care. The authors recommend that prior to handover, a formal handover sheet be constructed that can be transferred as part of the handover process.

Source: CINAHL

60. Transfer out of intensive care: a qualitative exploration of patient and family perceptions.
Author(s): Chaboyer W, Kendall E, Kendall M, Foster M

Citation: Australian Critical Care, 01 November 2005, vol./is. 18/4(138-144), 10367314

Publication Date: 01 November 2005

Abstract: Objective: To examine perceptions of ICU transfer held by patients and their family members, focusing specifically on those aspects of transfer perceived as difficult and those perceived as helpful.

Source: CINAHL

61. Does intermediate care minimize relocation stress for patients leaving the ICU?

Author(s): Beard H

Citation: Nursing in Critical Care, 01 November 2005, vol./is. 10/6(272-278), 13621017

Publication Date: 01 November 2005

Abstract: Relocation stress is a phenomenon in which physical and psychological disturbances are experienced following transfer from one environment to another [Carpenito LJ. (2000). Nursing Diagnosis. Application to Clinical Practice, 8th edn]. The purpose of this review was to identify whether a period of intermediate care minimizes the problems associated with relocation stress after discharge from the intensive care unit (ICU) and before transfer to the ward. Methods of retrieving the literature involved identifying key terms, utilizing a range of databases and applying specific criteria in order to delineate the boundaries of the search. Using electronic and manual search methods, 11 studies were selected, both primary and secondary research. Following tabulation and critiquing of the studies, the findings of the review suggest that the factors which contribute towards relocation stress are the loss of one-to-one nursing, a reduction of visible monitoring equipment, lack of continuity of care and inadequate preparation of the patient for the transfer. The evidence also indicates that in order to minimize these factors, early planning and preparation of the patient for transfer are required, incorporating strategies of gradual reduction in nursing attention and monitoring equipment and the provision of information. Although the benefits of intermediate care are established as being advanced monitoring, appropriate nurse-to-patient ratio, heightened demonstration of expert knowledge and skill, there is no sufficient evidence to indicate a period of intermediate care that can ease the transition from the ICU to the ward.

Source: CINAHL

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62. Pilot study to show the loss of important data in nursing handover

Author(s): Pothier D., Monteiro P., Mooktiar M., Shaw A.

Citation: British journal of nursing (Mark Allen Publishing), November 2005, vol./is. 14/20(1090-1093), 0966-0461 (2005 Nov10-23)

Publication Date: November 2005

Abstract: A good nursing handover process is a crucial part of providing quality nursing care in a modern healthcare environment. The conservation of patient data during the handover process is vital to ensure good continuity of care and safe practice. Any errors or omissions made during the handover process may have dangerous consequences. The authors observed the handover of 12 simulated patients over five consecutive handover cycles between nurses. Three handover styles were used and the amount of data loss was recorded for each style. A purely verbal handover style resulted in the loss of all data after three cycles. A note-taking style (the traditional style used in most hospital wards) resulted in only 31% of data being transferred correctly after five cycles. When a typed sheet was
included with the verbal handover, data loss was minimal. Current handover methods may result in significant loss of important data that may impact on patient care. The authors recommend that prior to handover, a formal handover sheet be constructed that can be transferred as part of the handover process.

Source: EMBASE

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63. Nurse's consultation as a part of nursing of patients transferred from an intensive care unit to a ward [Finnish].

Author(s): Tuuliainen E, Lahtinen M
Citation: Sairaanhoitaja, 07 October 2005, vol./is. 78/10(11-13), 07857527
Publication Date: 07 October 2005

Abstract: A project was implemented at the South Karelia Central Hospital during which nurse's consultations between the intensive care unit and wards were initiated. Patients may have feelings of stress and anxiety when they transfer from the ICU, where the care personnel is always present and observes the patients, to a ward with no such services. On the other hand, the ward staff may experience it is difficult to care a patient transferred from the ICU. It is possible to support both the patient and the ward staff in the initial phase by a nurse's consultation. Additionally, these consultations enable increasing cooperation between the wards and the ICU. The criteria guiding the nurse's consultation were drawn up in the project.

Source: CINAHL

64. An intervention study to improve the transfer of ICU patients to the ward -- evaluation by ICU nurses.

Author(s): Mitchell M, Courtney M
Citation: Australian Critical Care, 01 August 2005, vol./is. 18/3(123-128), 10367314
Publication Date: 01 August 2005

Abstract: Introduction: This intervention study, directed towards patients' family members, examined the efficacy of a structured individualised method of patient transfer from the perspective of Intensive Care Unit (ICU) nurses. A specifically designed brochure provided topics for the nurses to discuss in regards to patient transfer and was used by ICU nurses to guide their communication with family members and give information about impending transfer. Families retained the brochure which contained specific information hand written by the nurse.

Source: CINAHL

65. A qualitative study of the experiences of patients following transfer from intensive care.

Author(s): Strahan EHE, Brown RJ
Citation: Intensive & Critical Care Nursing, 01 June 2005, vol./is. 21/3(160-171), 09643397
Publication Date: 01 June 2005

Immediately following discharge to wards. A Husserlian phenomenological approach was utilised to gain some understanding of the experience of patients following transfer from intensive care. Ten patients selected purposively comprised the sample. Interviews were performed on the wards 3-5 days following transfer from intensive care. Data was analysed utilising (Colaizzi's (1978)) [Colaizzi PF. Psychological Research as the phenomenologist views it. In: Valle R, King M, editors. Alternatives for psychology. New York: Oxford University Press; 1978. p. 48-71] procedural approach to phenomenological interpretation and analysis. Three major themes emerged: physical response, psychological response and provision of care. These provide a possible framework for patient assessment. Implications for future practice and study are discussed.

Source: CINAHL

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66. An intervention study to improve the transfer of ICU patients to the ward -- evaluation by family members.

Author(s): Mitchell ML, Courtney M
Citation: Australian Critical Care, 01 April 2005, vol./is. 18/2(61-68), 10367314
Publication Date: 01 April 2005
Abstract: Introduction: This study evaluates family members' perspective of transfer from an intensive care unit (ICU) to a general ward. This intervention study directed towards patients' family members, examined the efficacy of a structured individualised method of patient transfer from the perspective of families. A specifically designed brochure provided nurses with key points to discuss with families regarding the impending patient transfer. Families retained the brochure, which contained specific information hand written by the nurse.

Source: CINAHL

67. Managing change in the nursing handover from traditional to bedside handover - A case study from Mauritius

Author(s): Kassean H.K., Jagoo Z.B.
Citation: BMC Nursing, January 2005, vol./is. 4/, 1472-6955;1472-6955 (28 Jan 2005)
Publication Date: January 2005
Abstract: Background: The shift handover forms an important part of the communication process that takes place twice within the nurses' working day in the gynaecological ward. This paper addresses the topic of implementing a new system of bedside handover, which puts patients central to the whole process of managing care and also addresses some of the shortcomings of the traditional handover system. Methods: A force field analysis in terms of the driving forces had shown that there was dissatisfaction with the traditional method of handover which had led to an increase in the number of critical incidents and complaints from patients, relatives and doctors. The restraining forces identified were a fear of accountability, lack of confidence and that this change would lead to more work. A 3-step planned change model consisting of unfreezing, moving and refreezing was used to guide us through the change process. Resistance to change was managed by creating a climate of open communication where stakeholders were allowed to voice opinions, share concerns, insights, and ideas thereby actively participating in decision making. Results: An evaluation had shown that this process was successfully implemented to the satisfaction of patients, and staff in general. Conclusion: This successful change should encourage other nurses to become more proactive in identifying areas for change management in order to improve our health care system. 2005 Kassean and Jagoo; licensee BioMed Central Ltd.

Source: EMBASE

Full Text:
Available in fulltext at BioMedCentral
Meeting patient and relatives’ information needs upon transfer from an intensive care unit: the development and evaluation of an information booklet.

Author(s): Paul F, Hendry C, Cabrelli L

Citation: Journal of Clinical Nursing, 01 March 2004, vol./is. 13/3(396-405), 09621067

Abstract: BACKGROUND: Transfer from the intensive care unit to a ward is associated with a significant degree of relocation stress for patients and relatives. This can be stressful for ward nurses due to the dependency levels of patients and the ensuing increased workload. Furthermore the patient may require care, not normally undertaken in that clinical area, e.g. tracheostomy care. Patients may forget the verbal information given to them at the time of transfer and often have limited or no memory of the intensive care unit experience. This can cause anxiety and compound the feelings of stress associated with transfer. Many patients suffer psychological and physiological problems after intensive care unit, which can affect their recovery and quality of life. AIMS: The aim of the study was to develop an evidence-based information booklet for patients and relatives preparing for transfer from intensive care units. DESIGN: This collaborative study used an exploratory design with elements of the action research cycle. The study, conducted in three phases, involved identifying patients’ and relatives’ information needs around the time of transfer; designing and developing an information booklet; and the introduction and evaluation of the booklet into practice. METHODS: Semistructured interviews were used to elicit the views of patients and relatives regarding their information needs. Members of the multidisciplinary team were involved in identifying and reviewing booklet content. RESULTS: Evaluation identified positive outcomes relating to patients’ and relatives’ satisfaction with the information and enhanced communication with other wards and health care professionals. The study also highlighted the need for more staff education in relation to patients and relatives needs when transferring to a ward. CONCLUSIONS: This study has demonstrated the value of providing patients and relatives with written information regarding transfer from intensive care units. Furthermore the study confirmed the feasibility and importance of including patients and relatives in the process of booklet development to ensure that their needs for information are being met. RELEVANCE TO CLINICAL PRACTICE: Providing written information as part of a structured discharge plan is recommended. It provides patients and relatives with a resource that they can refer to at any time and that enhances verbal communication. The purpose of this information is to inform and empower patients so that they are better prepared for the transfer and recovery period.

Source: CINAHL

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Nursing handovers: do we really need them?

Author(s): Sexton A, Chan C, Elliott M, Stuart J, Jayasuriya R, Crookes P

Citation: Journal of Nursing Management, 01 January 2004, vol./is. 12/1(37-42), 09660429

Abstract: AIM: This study attempts to address the content of nursing handover when compared with formal documentation sources. BACKGROUND: The nursing handover has attracted criticism in the literature in relation to its continuing role in modern nursing. Criticisms include those related to time expenditure, content, accuracy and the derogatory terms in which patients are sometimes being discussed. METHODS: Twenty-three handovers, covering all shifts, from one general medical ward were audio-taped. Their content was analysed and classified according to where, within a ward’s documentation systems, the information conveyed could be located. FINDINGS: Results showed that
almost 84.6% of information discussed could be located within existing ward documentation structures and 9.5% of information discussed was not relevant to ongoing patient care. Only 5.9% of handover content involved discussions related to ongoing care or ward management issues that could not be recorded in an existing documentation source.

LIMITATIONS: The results of this study are representative of only one ward in one Australian Hospital. Specific documentation sources were also not checked to determine their content. CONCLUSION: Streamlining the nursing handover may improve the quality of the information presented and reduce the amount of time spent in handover.

Source: CINAHL

Full Text:
Available in fulltext at EBSCO Host

70. The hidden benefit: the supportive function of the nursing handover for qualified nurses caring for dying people in hospital

Author(s): Hopkinson J.B.

Citation: Journal of clinical nursing, March 2002, vol./is. 11/2(168-175), 0962-1067 (Mar 2002)

Publication Date: March 2002

Abstract: 1. The nursing handover is a key activity for nurses working in acute hospital wards in the NHS. Little scholarly attention has been paid to the use nurses make of the information exchanged during nursing handover or how certain features of the nursing handover might impact positively or negatively on patient outcomes. 2. This paper draws on data from a phenomenological study of 28 qualified diploma nurses. 3. During the course of non-directive semi-structured interviews, some of the participants in this study expressed the opinion that nursing handover was helpful in enabling them to work with dying people in the acute hospital medical wards in which they worked. 4. The nurses identified two important functions of the nursing handover. The first was as a forum for discussing opinions and expressing feelings. The second was as a source of information on which to base their nursing decisions and actions. 5. It is proposed that some qualified nurses need help with the emotional labour of caring for dying people and that the nursing handover can assist in emotional adaptation, so enabling the management of troubling thoughts or feelings experienced in the course of caring for someone who is dying. 6. The role of the nursing handover in providing emotional support for nurses has been little studied and is a potentially useful area of future research, especially if it can be related to patient experiences and outcomes.

Source: EMBASE

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71. A qualitative study of shift handover practice and function from a socio-technical perspective.

Author(s): Kerr MP

Citation: Journal of Advanced Nursing, 15 January 2002, vol./is. 37/2(125-134), 03092402

Publication Date: 15 January 2002

Abstract: BACKGROUND: A qualitative study of shift handover practice and function from a socio-technical perspective Background. Shift handover plays a pivotal role in the continuity of patient care in 24-hour nursing contexts. The critical nature of this communication system is recognized within the literature and by the nursing profession; however, there are few in-depth studies. The rationale for this study is to gain a better understanding of handover practices and functions and their implications for effectiveness.

METHOD: Handover systems on two very different paediatric wards were selected as case
studies. In each case, 20 handovers were observed and audio-taped and 12 individual and two-group interviews with nursing staff about handover were also conducted. Analysis involved categorizing the data and characterizing handover practices and functions using an inductive approach to generate qualitative themes. The ethics committees of the hospital and the university approved the research. All involved were fully informed about the study, with confidentiality maintained throughout. RESULTS: Handover practices are distributed over time, socially among the staff and technologically through a range of artifacts, while the system also accomplishes informational, social and educational functions. Handover effectiveness is characterized by flexibility in managing competing demands and tensions, such as maintaining confidentiality while practising family centred care. There are limitations in how far the findings can be generalized to other nursing contexts, and the possible effects of the researcher's presence are also recognized. CONCLUSIONS: Handover is a complex system based on several sound socio-technical principles and the value of this nurse-to-nurse communication should be acknowledged. The multiple functions highlight the knowledge and expertise currently hidden within handover, which could be promoted in terms of nursing professionalism.

Source: CINAHL

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Available in print at Grantham Hospital Staff Library
Available in print at Pilgrim Hospital Staff Library

72. Exploring the need for change in nursing handover, using action research and case study methodology: a report on work in progress.

Author(s): Hardy JL, Howarth T, Ryan K, Henderson K

Citation: Nursing Monograph, 01 January 2002, vol./is. /(22-27), 13286137

Publication Date: 01 January 2002

Abstract: The purpose of the study is to explore nursing interaction within the context of the nursing handover. The traditional nursing handover is defined as a verbal communication where information about patients under the nurses care is exchanged (when nurses change shifts).

Source: CINAHL

73. Challenging the handover ritual. Recommendations for research and practice

Author(s): O'Connell B., Penney W.

Citation: Collegian (Royal College of Nursing, Australia), July 2001, vol./is. 8/3(14-18), 1322-7696 (Jul 2001)

Publication Date: July 2001

Abstract: Communicating nursing care during the patient's total hospital stay is a difficult task to achieve within the context of high patient turnover, a lack of overlap time between shifts, and time constraints. Clear and accurate communication is pivotal to delivering high quality care and should be the gold standard in any clinical setting. Handover is a commonly used communication medium that requires review and critique. This study was conducted in five acute care settings at a major teaching hospital. Using a grounded theory approach, it explored the use of three types of handover techniques (verbal in the office, tape-recorded, and bedside handovers). Data were obtained from semistructured interviews with nurses and participant field observations. Textual data were managed using NUD*IST. Transcripts were critically reviewed and major themes identified from the three types of handovers that illustrated their strengths and weaknesses. The findings of this study revealed that handover is more than just a forum for communicating patient care. It is also used as a place where nurses can debrief, clarify information and update knowledge. Overall, each type of handover had particular strengths and limitations; however, no one type of handover was appraised as being more effective. Achieving the multiple goals of handover presents researchers and clinicians with a challenging task. It is necessary to
explore more creative ways of conducting the handover of patient care, so that an important aspect of nursing practice does not get classified as just another ritual.

Source: EMBASE

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