I'm not a bot



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Giving an in-depth handover allows you to go home safe in the knowledge that your patients? Your mentor has asked you give handover. Panic rises at the thought of speaking to a room full of people about something your estill learning. Questions start running through your mind Did Bed 12
have any breakfast? What tests did the doctor order for Bed 4? How many patients are even on the ward?!Its nerve-wracking and you can feel as though youve been put on the spot. But handovers are arguably one of the most important things for you to master. The
NMC code of conduct instructs nurses to work with colleagues to monitor the quality of their work and maintain the safety of those in their care. Handovers give staff the opportunity to discuss the treatment theyre giving, communicate problems and concerns and ensure everyone knows exactly whats going on. By doing this, the team can prevent
 jobs from being missed or repeated. As a student, you can also use this opportunity to ask questions and familiarise yourself with the nursing process. Sarah Harris, a third year student nurse from Ayr, Scotland, remembers her first experience of handovers. My concerns when I first started giving handovers were that people would dread it when they
found out I was giving it. My initial handovers were all over the place and Im surprised anyone got any useful information from me at all! Nursing speakOf course, if you dont understand whats going on then no matter how hard you concentrate, the handover will be a waste of time. Initially the hardest part of handovers was the abbreviations used,
recalls Sarah. Once I got used to these it was easier. But getting used to abbreviations is easier said than done. The usual studentnursingtimes.net advice still stands (Ask, ask and ask again!) but if thats not possible, make a note of terms that are new to you and speak to someone afterwards or you can look them up here: Nursepedia. For help with
mental health terms have a look at: Decoding your mental health placement. What goes in to a handover? The handover of each patient is generally made up of three sections: Past: historical info. The patients diagnosis, anything the team needs to know about them and their treatment plan. So youd include things like whether they are nil-by-mouth or
require barrier nursing, if they need help with eating or using the toilet. If they are newly admitted then its a good idea to cover the circumstances leading to their treatment plan. Keep in mind that significant changes might have occurred before
your shift that the new team are not aware of; check when they were last in and what they already know. Include physical observations and any results from assessments or investigations. Future: what is still to be done. For lots of reasons, there can be jobs that have to be handed over to the next shift. Tasks that need to be completed at a certain time
or something the team simply havent had time to do yet. What needs to be happen for this patient to be discharged? Potentially there is a lot of information that could be handed over. Sarah found that prioritising the most important points and identifying who she was handing over to, helped her to give relevant handovers. I used to give every single
piece of information I had, even if it wasnt relevant. It doesnt really matter to night staff if the patient has a package of care at home but I do need to tell them that their vital signs are abnormal and that they are at risk of deterioration overnight. So how do you prioritise? Take a step back and think about what the team need to know. If you struggle to
decide whats important and whats less so, a good idea is to make notes before you start. Try using a simple table like the one below to help you get what your notes with you. Name/Bed numberDiagnosisSpecial notesPresentationTasksJohn Bloggs, Bed 12Acute
renal failureMRSA positive, barrier nursed, pressure sore on right leg.Slept most of morning. No change to treatment plan. Dressings need changing at 17:00. Hourly obs. Paul Jones, Bed 17Schizophrenia Nursed on 1:1 obs. Diabetic. Caught smoking in bed area, lighter confiscated. Compliant with oral medication. BMs 5.8 before lunch. Needs
depot. Continue 1:1 observations. Encourage to attend to hygiene needs. Beating the nervesYes its scary. Theres no getting away from that. But, like most things, the best way to get over that fear is to dive straight in. During handover, it is more important than ever to speak up if you are unsure, it sounds obvious but never make up what you think is
 happening! If you dont know what a patients blood pressure is, say you dont or better yet check their chart. Next time youll know to check beforehand. Youre there to learn so its reasonable to ask to just handover one or two patients to build up your confidence before you hand over the whole ward. Sarah had positive experiences of working with
 mentors to learn how to hand over: Going through the report with me and making sure I understood everything that had been handed over really helped. Practicing handover? bit.ly/ttaFOB studentnursingtimes (@studentNT) December 5,
2011 A nurses day wont be complete without nursing handover. Its when one nurse hands over not just the responsibility of care but also all the information concerning patients. In general, nurses can categorize the sections of a nursing handover into three parts: A. PastThis section involves everything the healthcare team needs to know about the
patient and the plan of care. For example, if your patient is newly admitted, you may need to cover the important pieces of information prior to admission. B. PresentIn this section, you can talk about the patients condition during your shift. This is also where youll discuss any changes in the treatment plan, completed procedures and tests, and any
 important orders from the doctors. C. Future Discuss the tasks that are required to be completed at a certain time. Styles of nursing handover some nurses are used to doing handovers while talking to each other. There are nurses who do it
 while reading the patients notes. For some nurses, doing handovers at the patients bedside is better because it allows patients to contribute if they want to. It also enables patients to clarify things. Quality of sleep is a good example. A patient may appear like he had a good nights sleep to the nurse. If thats not the case, he can easily clarify it and
correct the nurse. When doing bedside handovers, its important to avoid paternalism. This can happen when nurses communicate in a way that the patients dont understand. It confuses them and makes them feel uncomfortable. Tips for An Effective Handover1. Be organized in nursing, organization is next to godliness and that applies to nurse
handovers, too. Think of it this way: If you are telling lab results in the middle of explaining your head to toe assessment, youre not being organized. This isnt just frustrating for the other nurses but it can also cause you to leave out important details. Moreover, other nurses wont be able to follow you. To give you an overview, heres an example of how
you should give your reports. Consider this as a brief introduction of the patient. You dont need to tell every single detail that can be read on the patients. Be clear and concise with this. You dont need to tell every single detail that can be read on the patients current
presentation. For example, if the patient has a history of emphysema, you can tell the other nurse if hes on home oxygen and how many hours a day. For this, explain the treatment that has already been given as well as what the healthcare team is currently doing. Also, include important details like phobias, allergies, and even family dynamics. Explain
any tasks that need to be handed over to the next nurses as well as the path of the treatment. Some healthcare institutions follow or use a predetermined framework. If yours dont have one, you can create your own following certain national guidelines. One of them is the National Early Warning Score System. Its a tool created by the Royal College of
Physicians to prioritize physiological observations of patients. The SBAR (Situation-Background-Assessment-Recommendation) framework is another good tool. 3. Focus There are nurses who love to talk. While theres nothing wrong with that, you should keep in mind that the receiving nurses dont need to know everything that happened in your entire
 shift. You need to focus on important details and dont ramble on about your shift or the patient.4. Prioritize confidentialityWhen discussing important information at the station or at the bedside. Private information should only be heard by
the right people. Accountability and honesty are critical in nursing handovers because they affect how the incoming nurse will care for the patients. Missing out or omitting something important may compromise the patients. Avoid
repetitionIf you go on with routine information, such as diagnosis and age, you may not get to the things the incoming nurse doesnt know. 7. Allow time for queriesAfter a handover, give enough time for the other nurse to ask questions or clarify things. Doing this will help avoid confusion. Apart from that, asking questions also allows tired nurses to
remember things they forgot to include in their report. If you are on the receiving end, make sure to listen carefully. Avoid asking questions until the person is done. If you interrupt the nurse in the middle of a handover, shell likely get distracted. Nurses, in general, arent taught how to do handovers correctly. Most of us have learned it by watching
others. If you are new to doing handovers, make sure to pay attention to how others do it in your institution. Its easy to feel nervous when giving reports to veteran nurses but you have to stay calm and focused. Remember, the patients care will depend on the information youll relay to the receiving nurse. As a veteran, its easy to feel at ease during
handovers, particularly since youve done it most of your career. However, as a nurse, it helps to stay updated with the latest trend. Try to look for ways to make handovers more effective and efficient on your part. Apart from that, dont rush the receiving nurse, particularly if shes new to your area. Rushing the process can cause vital pieces of
information to be left out. As a library, NLM provides access to scientific literature. Inclusion in an NLM database does not imply endorsement of, or agreement with, the contents by NLM or the National Institutes of Health. Learn more: PMC Disclaimer | PMC Copyright Notice An accurate handover of clinical information is of great importance to
continuity and safety of care. If clinically relevant information is not shared accurately and in a timely manner it may lead to adverse events, delays in treatment and diagnosis, inappropriate treatment and omission of care. During the last decade the call for interventions to improve handovers has increased. These interventions aim to reduce the risk
of miscommunication, misunderstanding and the omission of critical information. To determine the effectiveness of interventions designed to improve doutcomes for patients in the hospital setting and which nursing handover style(s) are
associated with improved nursing process outcomes. We searched the following electronic databases for primary studies: Cochrane Central Register of Controlled Trials (CENTRAL) (to 1 March 2013), MEDLINE (1950 to 1 March 2013) OvidSP, EMBASE (1947 to 1 March 2013)
OvidSP, CINAHL (Cumulative Index to Nursing and Allied Health Literature) (1980 to 1 March 2013) EbscoHost and ISI Web of Knowledge (Science Citation Index of Reviews (DARE) was searched for related reviews. We screened the reference lists of included studies and
relevant reviews. We also searched the WHO International Clinical Trials Registry Platform (ICTRP) and Current Controlled trials (RCTs or clusterRCTs) evaluating any nursing handover style between nurses in a hospital setting with
the aim of preventing adverse events or optimising the transfer of accurate essential information required for continuity of care, or both. Two review authors independently assessed trial quality and extracted data. The search identified 2178 citations, 28 of which were considered potentially relevant. After independent review of the full text of these
studies, no eligible studies were identified for inclusion in this review due to the absence of studies with a randomised controlled study design. There was no evidence available to support conclusions about the effectiveness of nursing handover styles for ensuring continuity of information in hospitalised patients because we found no studies that
fulfilled the methodological criteria for this review. As a consequence, uncertainty about the effective practice remains. Research efforts should focus on strengthening to current knowledge, the following guiding principles can be
applied when redesigning the nursing handover process: facetoface communication, structured documentation, patient involvement and use of IT technology to support the process. What is a nursing handover occurs when one nurse
hands over the responsibility of care for a patient to another nurse, for example, at the end of a nursing shift. On average, nursing handovers are done in various ways, some handovers are done through nurses talking to each other (verbal
handovers). Others are done through nurses reading the patients medical notes or through a combination of reading and talking to each other. In some cases they are done at the patients bedside, so that the patients medical notes or through a combination of reading and talking to each other. In some cases they are done at the patients bedside, so that the patients medical notes or through a combination of reading and talking to each other. In some cases they are done at the patients medical notes or through a combination of reading and talking to each other.
care to another nurse there is an opportunity for error if all the important medical information is not shared thoroughly and efficiently. Failing to mention or grasp information may result in delays in treatment, or failure to provide appropriate care. Consequently, an accurate handover of clinical
information is essential to ensure continuity of care and findings of this review tried to find out which nursing handover style works best. In March 2013 the review authors conducted a wide search for suitable relevant studies (randomised controlled studies) that compared different styles of nursing
handover. However, they were not able to identify any randomised controlled studies that investigated the question, and so could draw no conclusions. Further research in this area is urgently needed. In its 2001 report, 'Crossing the Quality Chasm' the Institute of Medicine (IOM) stated that handovers provide an opportunity for error and that in a
safe system, information is not lost, inaccessible, or forgotten in transitions (IOM 2001). In a 2009 hospital staff respondents reported thatimportant patient safetyculture, hospital staff respondents reported that important patients are not appeared to the safetyculture and hospital staff respondents reported that important patients are not appeared to the safetyculture and hospital staff respondents reported that important patients are not appeared to the safetyculture and hospital staff respondents reported that important patients are not appeared to the safetyculture and hospital staff respondents reported that important patients are not appeared to the safetyculture and hospital staff respondents reported that important patients are not appeared to the safetyculture and hospital staff respondents reported that important patients are not appeared to the safetyculture and hospital staff respondents reported that important patients are not appeared to the safetyculture and hospital staff resp
healthcare professionals is an oftencited key factor contributing to errors and procedural mistakes, which may lead to adverse events (AEs). Breakdowns in communication were implicated as one of the main causes of AEs reported to the Joint Commission in the USA between 2004 and 2010 (Joint Commission 2011). In an Australian study of more
than 14,000 admissions, 17% were associated with an AE; in 11% of these communication problems were found to be a contributing factor (Wilson 1995). Handovers of patient care thus introduce a 'vulnerable gap' that may result in AEs if clinically relevant information is not shared accurately and in a timely manner (Bhabra 2007; Handover Europe
2011; Pothier 2005). Other consequences of a poor handover might be delays in diagnosis or treatment (Joint Commission 2002), inappropriate treatment and omission for both healthcare provider and patient, increased costs,
increased length of hospital stay and more readmissions (Patterson 2010). As a result, it is now well recognised that an accurate handover of clinical information is of great importance to continuity and safety of care. This specific
scope is chosen as nurses are pivotal in ensuring continuity of care in a 24hour sevendaysaweek environment, not only since they are present both day and night (Messam 2009), but also because they are seen as a communication partner for all healthcare professionals and are often the (in)formal coordinators of the increasingly complex care that is
given within hospitals (IOM 2010). To fulfil this role a complete and up to date picture of the patient's care plan has to be handed over frequent parttime working among nurses, handovers occur between many different nurses. Usually handovers are
 timeconsuming, lack consistency and are varied in style (Clark 2009; Kerr 2011; Sexton 2004), and nursing handovers are no different. Furthermore, nurses, just like most healthcare professionals, may receive no formal training in the handover process other than by modelling from peers and superiors (Van Eaton 2010). As a consequence, the
nursing handover is a vulnerable process with potential to result in AEs, unnecessary duplication of work or suboptimal care. Although the literature so far has not provided a thorough or agreed definition of the concept of handover and its scope, continuity of patient care is its primary function (Sherlock 1995; Thurgood 1995). The distinctive feature
that distinguishes a handover from other (in)formal communication about patients is the transfer of professional responsibility for the quality, safety and satisfaction of the patient. Within this review we define a handover as the exchange of specific information about
a patient from one health professional to another, or from one team of health professionals to another, accompanied by the transfer of responsibility for that patient with the purpose of ensuring the continuity and safety of the patient's care (Cohen 2010; Jeffcott 2009). The scope of this review covers the exchange of information about content (the
'what' aspect), as well as the way, or method, in which it is communicated (the 'how' aspect) (Murphy 2009). Content can be structured. Method refers to the communication methods, e.g. verbal, written or taped. In addition to the content and method, the location (the
 where aspect) of the handover may also differ. Location can be either bedside or officebased. We define a handover style as any combination of the abovementioned characteristics, that is, content ('what'), method ('how') and location ('where') (Kerr 2002; Sexton 2004). Literature frequently identifies the following nursing handover styles: bedside,
 verbal, nonverbal and taped (Messam 2009). Bedside: located at the patients bedside, which promotes patient and nurse facetoface interaction and encourages patients verbal participation, thus making the patient central to the information exchange process (Greaves 1999; Kassean 2005). Verbal: located in an office setting, the nurse responsible for a
group of patients exchanges relevant documented information (Bourne 2000; Lally 1999). Nonverbal: located in an office setting, nurses inform themselves by reading the patient health record, involving progress notes, medication charts, observation charts, observation charts, observation charts and nursing care plans (Taylor 2002). Taped: located in an office setting, nurses inform themselves by reading the patients and nursing care plans (Taylor 2002). Taped: located in an office setting, nurses inform themselves by reading the patients and nursing care plans (Taylor 2002). Taped: located in an office setting, nurses inform themselves by reading the patients and nursing care plans (Taylor 2002). Taped: located in an office setting, nurses inform themselves by reading the patients and nursing care plans (Taylor 2002). Taped: located in an office setting, nurses inform themselves by reading the patients and nursing care plans (Taylor 2002). Taped: located in an office setting, nurses inform themselves by reading the patients and nursing care plans (Taylor 2002). Taped: located in an office setting, nurses inform themselves by reading the patients and nursing care plans (Taylor 2002). Taped: located in an office setting, nurses inform themselves by reading the patients and nurses inform the patients and nurses information the patients a
collects the relevant information and records this onto an audiotape so that the oncoming shift can listen at a convenient time (Dowding 2001). During the last decade the call for interventions to improve handovers has increased (AMA 2006; AHRQ 2009; BMA 2005; IOM 2001; Joint Commission 2002; WHO 2006). These interventions aim to reduce the
risk of miscommunication, misunderstanding and the omission of critical information, therefore, it is important to find out what constitutes an effective nursing handover style (Patterson 2010; Riesenberg 2010). As mentioned above, handovers of patient care may result in AEs if clinically relevant information is not shared accurately and in a timely
 manner. Other consequences of a less than perfect handover might be delays in treatment and diagnosis, inappropriate treatment and omission of care. However, inefficiency due to rework, redundant communications and redundant activities may also result in lower satisfaction for both healthcare provider and patient, increased costs, increased
length of hospital stay and more readmissions. We considered any nursing handover style (what, how and where) between nurses in a hospital setting with the aim of preventing AEs or optimising the transfer of accurate essential information required for continuity of care, or both. This includes: nurses in a hospital setting with the aim of preventing AEs or optimising the transfer of accurate essential information required for continuity of care, or both. This includes: nurses in a hospital setting with the aim of preventing AEs or optimising the transfer of accurate essential information required for continuity of care, or both.
different levels of care, such as: regular wardbased care, highdependency care and intensive care unit (ICU); nursetonurse transfers during a shift to balance workload; nursetonurse interdepartmental transfers during a shift to balance workload; nursetonurse interdepartmental transfers, such as between nursing ward, from the emergency department (ED) to the nursing ward, from the recovery unitto the nursing ward, from
the ICU to the nursing ward or the other way round. The review does not include: handover from a primary care setting to a hospital setting by a primary care setting to a hospital setting by a primary care physician to a nurse; handovers from hospital to home or to another healthcare
 facility upon discharge. Generally handover interventions aim to incorporate a tool or routine into practice that implements a standardised communication patterns allowing for questions or for information to be read back. Use of the tool or routine is intended to support the
that is different from the actual condition); a decrease in omissions (information at handover that could increase inefficiency); a reduction of time spent resolving issues from incomplete communication at handover that if left out of the handover that could increase in efficiency and efficiency are efficiency and efficiency and efficiency are efficiency and efficiency and efficiency are efficiency as efficiency and efficiency are efficiency as efficiency and efficiency are efficiency as efficiency are efficiency as efficiency and efficiency are efficiency as efficiency are efficiency as
 ineffective handover, and also reduce the amount of time spent on handovers, thereby freeingup time that can be spent in direct patient care (Sexton 2004). Since handovers have been identified as a primary communication moment, many organisations, institutions and hospitals have initiated quality projects to improve handovers. In the 'High 5s
 Project', launched by the World Health Organization (WHO) in 2006, one of the five patient safety problems targeted was 'Communication failures during patient to understand the effectiveness of interventions aimed at improving nursing handovers and
consequently ensuring continuity of care, as well as preventing AEs. Since the WHO and national government agencies are promoting handover interventions to improve patient safety (WHO 2007), these policy decisions should be based on evidence of the effectiveness of these interventions. There are risks involved in implementing interventions for
 improve hospital nursing handover, specifically:to identify which nursing handover style(s) are associated with improved outcomes for patients in the hospital setting and which nursing handover style(s) are associated with improved outcomes for patients in the hospital setting and which nursing handover style(s) are associated with improved outcomes. We considered randomised controlled trials (RCTs or clusterRCTs) to be eligible for
 inclusion (according to the definition of the Cochrane Effective Practice and Organisation of Care (EPOC) Group). We considered published and unpublished and unpublished studies to be eligible and we imposed no language restrictions. All patients irrespective of age, gender or condition; and nurses in either general, teaching or university hospitals. Any intervention
 designed to improve nursing handover in a hospital setting compared with a previous or existing hospital nursing handover practice or an alternative intervention as defined by the study. Intervention as defined by the study are study.
structured (e.g. including templates, mnemonics or checklists, or a combination possibly combined with standardised communication patterns allowing for questions or for information to be read back. Written handovers
can be facilitated by either paperbased or electronic systems. Location could be either bedside or office based. If at least one of the abovementioned characteristics constituted part of a handover in an office setting versus a verbal handover in an office
bedside with a standardised communication approach versus verbal handover in an office setting as in common practice. If different comparisons were found, these would be taken
 into account, as long as the intervention targeted one or more of the following characteristics: content (structured, semistructured or unstructured), method (e.g. verbal, written and taped) or location of the handover (e.g. bedside or officebased). Patient outcomes: any objective measure for preventable AE (patient safety) measured by, for
number correct, number omitted, number incorrect);improved compliance with the plan of care (measured, for example, by adherence indicators);timely delivery of care);a decrease in incongruent information (information given at handover that is
different from the actual condition); a decrease in omissions (information to the handover (either increase or decrease) in relation to the effectiveness of the handover (either increase or decrease) in relation to the effectiveness of the handover (either increase or decrease) in relation to the effectiveness of the handover (either increase in omissions); a decrease in omissions (information to the effectiveness of the handover). Time required for handover (either increase in omissions) and increase in omissions (information to the effectiveness of the handover). Time required for handover (either increase in omissions) and increase in omissions (information to the effectiveness of the handover). Time required for handover (either increase in omissions) and increase in omissions (information to the effectiveness) and information to the effectiveness (information to the effectiveness) and information to the effectiveness (information
 Information Specialist and Trials Search Coordinator for the EPOC group. The Database of Abstracts of Reviews (DARE) was searched for related reviews. Searches for the Cochrane EPOC Group Specialised Register and ISI web of Knowledge were
 developed and conducted in July and September 2012 by the Information Specialist and Trials Search Coordinator for the EPOC group. The search strategies are provided in Appendices one to six. Cochrane EPOC Group specialised register (to
19 September 2012) (Appendix 1)Cochrane Central Register of Controlled Trials (CENTRAL) (Issue 2, 2013) (to 1 March 2013) OvidSP (Appendix 2)MEDLINE (1950 to 1 March 2013) OvidSP (1950 to 1 March 
 EbscoHost (Appendix 5)ISI Web of Knowledge (Science Citation Index and Social Sciences Citation Index) (to 9 July 2012) (Appendix 6)The search strategies were comprised of keywords and, when available, controlled vocabulary such as MeSH (Medical Subject Headings). Keywords used included: handover, handoff, change of shift, sign out, and
MeSH terms: patient transfer, patient transfer, patient care management. Neither date nor language restrictions were used to limit retrieval to appropriate study designs: namely, the Cochrane Highly Sensitive Search Strategy
 (sensitivity and precisionmaximizing version, 2008 revision) to identify randomised trials (Higgins 2011; section 6.4d); and an EPOC methodology filter to identify studies that are not indexed in the databases listed above using the following sources: European handover initiative
(URL now inactive Sept, 2021); International WHO Collaborating Centre for Patient Safety Solutions (www.ccforpatientsafety.org/). The search terms used were: handover, handoff, sign out, shift change, inter shift, transfer. We also: Reviewed reference lists of
relevant systematic reviews (Appendix 7). Data collection and anlaysis is described below. We downloaded all titles and abstracts retrieved by the electronic searching to the reference managing database Reference Manager 12. Two reviews (MS and HV) independently screened all titles and abstracts identified through the search strategies to
 assess which studies met the inclusion criteria. We retrieved and assessed fulltext copies of all papers that were potentially relevant for inclusion. Any disagreement was resolved through discussion between the review authors. We had planned to have two authors independently extract appropriate information regarding the characteristics of each
 included study, using a data abstraction form based on the EPOC Group template. We intended to extract the following data. Study reference: author name, publication yearStudy design: RCT or clusterRCTParticipants: number of participating nurses, age, level of training and years in practiceSetting: country, type of hospital, type of
 department/specialityIntervention: description of the nursing handover intervention, classified according to whether the intervention of control group usedOutcomes: measures used to assess patient outcome, process and efficiency outcomesResults: main
 results of all outcome(s)Where needed, we planned to contact study authors (if possible) to obtain missing information. We had planned that eligible studies would be independently assessed on methodological quality using the Cochrane 'Risk of bias' tool, the EPOC Group criteria for randomised controlled trials and the GRADE approach (EPOC 2009;
GRADEpro 2010; Higgins 2011). These checklists assess the validity of study design (method of randomisation; allocation concealment; imbalance of outcome measures at baseline; blinding of participants, personnel and outcome assessors; incomplete outcome data; method of data collection; appropriate statistical methods) and the effect and
 applicability of the results (magnitude of effect; imprecision; inconsistency; indirectness). We planned to report pre and postintervention proportions (dichotomous outcomes, such as AEs, we intended to calculate the risk ratio (RR) and the risk difference (RD)
together with their respective 95% confidence intervals (CI). For studies reporting continuous outcomes, such as time, we planned to calculate the mean difference (MD) together with a 95% CI. When necessary we intended to contact the first or corresponding author for clarification or additional information. Had authors not reported or supplied to contact the first or corresponding author for clarification or additional information.
data in sufficient detail after we had contacted the point estimates with 95% CI or a P value, as stated by the author. We would have reported the primary measure (as defined in the methods
methods assume independence of observations, and their use in these types of studies will generally result in artificially small P values and overly narrow 95% CI for the effect estimates (Ukoumunne 1999). We planned to attempt to reanalyse studies with potential unit of analysis errors if information was available about the size/number of clusters
and the value of the intracluster correlation coefficient (ICC). If a comparison had been reanalysed, we would have quoted the P value and annotated it as 'reanalysed'. If the ICC was not available we intended to attempt to obtain it by contacting trial authors, or by imputing it using external estimates from similar studies (Ukoumunne 1999), or using
 general recommendations from empirical research (Campbell 2000). If this had not been possible we would have reported the effect estimate and incorporate this information into the analysis. We would have annotated this
 information as as provided after contact with the author. We expected to find both clinical and statistical heterogeneity due to differences in the types of intervention, types of setting, definition of outcome measures and study design. This made it unlikely that statistical pooling would be feasible, but if there appeared to be a body of studies amenable
to metaanalysis, then we planned to display the results graphically to assess heterogeneity. We would have considered I statistic values of 50% or greater as indicative of significant heterogeneity. We would have refrained from pooling and restricted the analysis to a qualitative overview. If there had been sufficient
 homogeneity in populations, study design and outcome measures (i.e. where I < 50%) (Higgins 2003), we would have pooled results. We had planned to construct a funnel plot analysis to assess publication bias existed when we detected asymmetry in
the funnel plot. We also intended to use the Egger test to assess funnel plot asymmetry (Egger 1997). A thorough search for unpublished studies through search for unpublished
reporting bias by comparing either the study protocol (if a vailable) or the methods section (if a protocol was not available) to the reported results of the study. A metaanalysis would have been considered only if we had had two or more studies that were homogeneous regarding population, interventions, comparisons and outcomes. In instances where
metaanalysis would not be possible, we planned to report the results as a descriptive narrative only. For studies that were sufficiently clinically homogenous (I < 50%), we planned to report the results as a descriptive narrative only. For studies that were sufficiently clinically homogenous (I < 50%), we planned to report the results as a descriptive narrative only. For studies that were sufficiently clinically homogenous (I < 50%), we planned to use a randomeffects model.
performed data synthesis using Review Manager 5.2 (RevMan 2011). Furthermore we intended to use GRADEpro 2010). Had sufficient data been available, we planned to perform subgroup analyses to compare outcomes for: shift to shift handover on nursing wards
providing different levels of care, such as: regular wardbased care, high dependency care and ICU; interdepartmental handover: from one ward to another ward, from recovery to ward, from ward to another ward
 analysis to explore the impact of the following study characteristics: fixedeffect versus randomeffects analysis; odds ratios versus risk ratios; and studies with imputed standard deviations. The search identified 2178 citations. Independent examination by the reviewers resulted in retrieval of 28 publications
that were potentially eligible for inclusion in the review (Figure 1). After assessment of the full text of these studies, no study was found to meet the inclusion criteria. A description of the retrieved studies and the reasons for their exclusion are presented in the 'Characteristics of excluded studies' section. Flow diagram of searchNo eligible studies
 were found for inclusion in this review. Main reason for exclusion was that the studies did not meet the RCT study design: 18 studies used a simple beforeandafter design (Antonoff 2012; Hussain 2011; Jukkala 2012; Radtke 2013; Raptis 2009; Baldwin 1994; Benestante 2008; Chung 2011; Craig 2012; Dean 2012a; Evans 2012; Hussain 2011; Jukkala 2012; Radtke 2013; Raptis 2009; Baldwin 1994; Benestante 2008; Chung 2011; Dean 2012a; Evans 2012a; Evans 2012a; Evans 2012a; Dean 2012a; Evans 2
Stahl 2009; Streitenberger 2011; Thomas 2012; Tucker 2009; Wentworth 2012) three studies were opinion papers (Benaglio 2006; Dean 2012b; Ten Cate 2012), two studies were editorials (Moore 2012; Rabol 2011,) one study was a simulation study (Dowding 2001), one study
performed post implementation evaluation only (Alvarado 2006) and one study was a project description (Aellig 2012). In addition four of the studies were not on nursing handover (Aellig 2012; Antonoff 2013; Dean 2012a; Hussain 2011). The detailed description of retrieved studies and reasons for their exclusion are presented in the 'Characteristics
of excluded studies' section. No eligible studies were found for inclusion in this review, so we made no assessment of selection bias. No eligible studies were found for inclusion in this review, so we made no assessment of performance or detection
 bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of other sources of bias. No eligible studies were found for inclusion in this review, so we made no assessment of the bias.
 for inclusion in this review, so we cannot report any effects of interventions. We did not find any randomised studies and could not include any studies that fulfilled our methodological criteria for this review. Therefore, we are unable to draw any conclusions about the effectiveness of different nursing handover styles for ensuring continuity of
information in hospitalised patients. This is disappointing in view of the important role of the nursing handover we identified three publications from two randomised studies comparing usual care to an intervention (Lea
1996; Van Eaton 2005; Van Eaton 2010), which indicates that it is possible to apply this design for evaluation of handover styles. One study used a randomised crossover design and the other study used a short time frame (three and five
months respectively). The outcomes measured were efficiency (workflow and time), continuity of care, safety (adverse events) and selfreported assessment of the new procedure. Although no reliable evidence exists yet, there are many examples of researchers attempting to evaluate effectiveness of nursing handover styles in order to improve patients.
 safety and quality of care (listed within the Characteristics of excluded studies). Most of these studies (18 out of 28 studies) were limited to simple beforeandafter designs of local experiences with quality improvement (QI) initiatives in which the handover practice and how it was performed was described to a varying degree, making reproduction
 difficult. The handover practice was often evaluated at the level of selfreported satisfaction (six studies on nurse satisfaction and two on patient satisfaction) and not at the level of effectiveness. The topic of nursing handover has received considerable attention lately, but the studies designed so far are at a high risk of bias, generate only local
 knowledge or have not been designed to generate effectiveness data (Glasziou 2011; MRC 2000; Ovretveit 2011; Shojania 2004; Shojania 2005). There is an urgent need for highquality studies to provide hospital management with appropriate evidence to guide decisions about the most effective nursing handover style. No eligible studies were found
 for inclusion in this review. This review. This review is complete, based on the evidence currently available. No randomised controlled trials were available for inclusion in this review. The major drawback of this design is a high risk of bias, since the excluded studies were simple beforeandafter evaluations of local experiences with QI initiatives. The major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of this design is a high risk of bias, since the major drawback of th
there is no control available and changes over time in patient populations, or changes in practice, that are unrelated to existing terminology by experienced clinical librarians. We searched a large number of
databases and relevant websites. Two review authors independently assessed all potentially eligible titles and abstracts against the eligibility criteria to ensure that no important references were missed. Additionally we searched reference lists of systematic reviews that were identified in the search. During the inclusion process for primary studies on the search of the searc
nursing handover we also identified 27 potential systematic reviews on handover (Appendix 7), six of which could be classified as systematic reviews (Arora 2009; Calleja 2011; Foster 2012; Ong 2011; Riesenberg 2010), staggers 2013), according to the DARE criteria (NIHR 2013). These reviews had wider inclusion criteria than this review regarding
methodology, consisting of QI studies using primarily simple beforeandafter designs and a wider scope that also included physician or interdisciplinary handover. Searching the references of these reviews revealed no high quality studies we might have missed in our search. Also a recent review by Scott revealed no RCTs, interrupted time series (ITS)
or controlled beforeandafter studies (CBA) (Scott 2012). All the reviews also concluded that the existing literature on patient handovers does not yet support definitive research conclusions, and all addressed the need for high quality studies. We found no eligible studies for inclusion in the review and therefore the review question remains
unanswered. As a consequence, uncertainty remains about the most effective nursing handover practice and, as previously noted, one can only rely on insights obtained from systematic reviews of studies with simple beforeandafter designs. Breakdowns in communication are one of the main causes of adverse events (AEs) and an accurate handover of
clinical information is of great importance to continuity and safety of care. According to current knowledge, the following guiding principles can be applied when redesigning the nursing handover process: facetoface communication, structured documentation, patient involvement and use of information technology to support the process. When
designing and implementing a quality improvement (QI) initiative to improve nursing handover one should consider conducting an evaluation using a robust design, (e.g. an interrupted time series (ITS) or a controlled beforeandafter (CBA) study) to strengthen the evidence about this topic. At present, high quality evidence on the effectiveness nursing
handover styles for ensuring continuity of information in hospitalised patients is lacking. Researchers wishing to evaluate the effectiveness of different nursing handover styles in hospitalised patients should use well designed rigorous studies. Experimental methods such as (cluster) randomised controlled trials (RCTs) are recommended because they
 offer protection from the effects of background variation. However their use in QI research may be beyond the capacity of many clinicians and researchers because of difficulty in blinding and concealment of allocation (Rotter 2010; Shojania 2004; Shojania 2005). Another feasible rigorous study design that can correct for the drawbacks of simple
beforeandafter designs is an ITS with at least three data points before and three data points after the intervention and also indicates the extent to which any trend toward improvement may have been present prior
to the intervention. When multiple time points before and after an intervention are not feasible, a reasonable alternative to a timeseries analysis is a CBA study, in which the same beforeandafter measurements occur in one or more hospitals that did not implement the change of interest but are otherwise comparable (EPOC 2009; Grimshaw 2000;
 Ramsay 2003). Within these designs interventions to improve nursing handover or structured formats for handover can be compared against usual care (i.e. unstructured handover format that is applicable everywhere, the context and local situation are
 AEs such as medication errors and patient falls, or complications such as pressure ulcers and nosocomial infections, as well as length of hospital stay and patient satisfaction (Burston 2013). Process outcomes that can be used include recall of information, compliance with the plan of care, time and interruptions. Since the incidence of AEs is not high
a sufficient number of participants (for RCT designs) or sufficient time interval (for ITS and CBA designs), or both, should be applied. DateEventDescription 30 September 2021 Amended The URL for the European handover initative was disabled as the site no longer reports detail on this project. Protocol first published: Issue 7, 2012 Review first
published: Issue 6, 2014DateEventDescription May 2014AmendedCopy editing suggestions processed 18 July 2013AmendedRevised search methods per template provided by EPOC TSC. Added an appendix listing the systematic reviews we scanned for related studies. Adapted the paragraph implications for future research according to epicot. We
thank Mr Arnold Leenders, clinical librarian at the Medical Library of the University of Amsterdam, for developing the search strategy. We thank Michelle Fiander, Information Specialist and Trials Search Coordinator for the EPOC group, for supervising and reviewing the search strategy. All NonIndexed fields {continuity of care} AND
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Did not meet RCT study design criteria as performed only a postimplementation of written and verbal shift handover for residents. Did not meet RCT study design criteria as only simple beforeandafter comparison was performed (on satisfaction with signouts, and pot on nursing handoverAthwal 2009Development, implementation and evaluation of a combination of written and verbal nursing shift handover at the bedside. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on the amount of time spent for shift report, overtime expenses related to shift report, call lights, staff satisfaction, and patient falls). Baldwin 1994Development, implementation and evaluation of a computergenerated written nursing shift handover. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on overtime and staff satisfaction)Benaglio 2006Opinion paper on nursing shift handover; did not meet RCT study design criteria as performed only simple beforeandafter comparison (on overtime and staff satisfaction)Benaglio 2006Opinion paper on nursing shift handover. evaluation of bedside nursing shift handover. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on nurses belief that bedside reporting improves patient safety). Chung 2011Development, implementation and evaluation of a standardised nursing shift report. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on staff opinions and overtime) Clair 1969 Qualitative study to find out what should be included in a nursing shift handover report and to determine the extent to which nurses acted upon their beliefs. Did not meet RCT study design criteria 2012 Development, implementation and evaluation of multidisciplinary structured verbal, written bedside handover from cardiac operating room to paediatric intensive care. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on handover score, staff perception, duration and number of interruptions). Dean 2012aDevelopment, implementation and evaluation of a standardised handover from ambulance to ED. Did not meet RCT study design criteria as performed only simple beforeandafter comparison and did not meet RCT study design criteria. Dowding 2001 Simulation of the effect that manipulating the style and content of the nurse shift handover had on an individual's ability to plan patient care, not in a clinical setting. Evans 2012 Development, implementation and evaluation of bedside nursing shift handover. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on nurses' job satisfaction and time spent delivering report) Hussain 2011 Development, implementation and evaluation of a weekend handover from cardiac operation room to ICU. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on technical errors) Jukkala 2012Development, implementation and evaluation of a structured written and verbal nursing shift report in a medical ICU. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on technical errors). beforeandafter comparison (on nurses perception of handoff communication during shift report) Moore 2012 Editorial; did not meet RCT study design criteria. Rabol 2011 Editorial; did not meet RCT study design criteria. Rabol 2011 Editorial; did not meet RCT study design criteria. unit. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on patient satisfaction)Raptis 2009Comparison of a paperbased and electronic as performed only simple beforeandafter comparison (on patient satisfaction)Raptis 2009Comparison of a paperbased and electronic as performed only simple beforeandafter comparison (on patient satisfaction)Raptis 2009Comparison of a paperbased and electronic as performed only simple beforeandafter comparison (on patient satisfaction)Raptis 2009Comparison of a paperbased and electronic as performed only simple beforeandafter comparison (on patient satisfaction)Raptis 2009Comparison of a paperbased and electronic as performed only simple beforeandafter comparison (on patient satisfaction)Raptis 2009Comparison of a paperbased and electronic as performed only simple beforeandafter comparison (on patient satisfaction)Raptis 2009Comparison of a paperbased and electronic as performed only simple beforeandafter comparison (on patient satisfaction)Raptis 2009Comparison of a paperbased and electronic as performed only simple beforeandafter comparison (on patient satisfaction)Raptis 2009Comparison of a paperbased and electronic as performed only simple beforeandafter comparison (on patient satisfaction)Raptis 2009Comparison (on patient satisfaction)Raptis 2009C performed only simple beforeandafter comparison (on patient details and patient location, primary diagnosis and current problem, plan of action and day team details) Stahl 2009Prospective cohort study of trauma and surgical ICU teams (interns, residents, and fellows) to determine whether a structured checklist for ICU handovers prevents information loss. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on data lost) Streitenberger 2011 Proceedings abstract on development, implementation and evaluation of a standardised nursing shift handover in 3 paediatric ICUs. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on data lost) Streitenberger 2011 Proceedings abstract on development, implementation and evaluation of a standardised nursing shift handover in 3 paediatric ICUs. not meet RCT study design criteriaThomas 2012Development, implementation and evaluation of a standardised beforeandafter comparison (on nurse and patient satisfaction)Tucker 2009Development, implementation and evaluation of a bedside 'reading' nursing shift handover. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (the standard of record keeping) Wentworth 2012Development, implementation and evaluation of an electronic handover communication tool for transferring uncomplicated routine patients to and from a progressive care unit and cardiac laboratories. Did not meet RCT study design criteria as performed only simple beforeandafter comparison (on implementation evaluation) The original MEDLINE search was responsible for the first and design. MS was responsible for the first and cardiac laboratories. nothing to declare Cees Lucas: nothing to declare Hester Vermeulen: nothing to declar Nursing 2012;43(6):261-6. [DOI] [PubMed] [Google Scholar]Alvarado K, Lee R, Christoffersen E, Fram N, Boblin S, Poole N, et al. Transfer of accountability: transforming shift handover to enhance patient safety. Healthcare Quarterly 2006;9 Spec No:75-9. [DOI] [PubMed] [Google Scholar] [PubMe Wagnell E. 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What is a handover in nursing. What makes a good nursing handover. What to include in a nursing handover. Why is handover important in nursing.