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

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Summary
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.

Role of handover
Information must be transferred from one shift of nursing staff to the next to provide "continuity and consistent patient care" (Hoban 2003). Pothier et al (2005) noted that handover is "a crucial part of providing quality nursing care... any errors or omissions made during the handover process may have dangerous consequences".

In a project to increase patient safety conducted in southern California, a number of areas were selected for improvement (Marquis and Huston 2009). The inclusion of ward handovers alongside a no blame culture coupled with education, performance measurement and smart technology, indicated that the transmission of accurate information is paramount.

The Code (Nursing and Midwifery Council 2008) states that nurses must "work with others to protect and promote the health and wellbeing of those in your care". Part of that work involves the communication of patients' details and treatment information to ensure the smooth transition of care.

Handovers occur on all wards and departments and have been described as almost a religious rite (Evans et al 2008). Staff often attend to handovers in their own time between shifts when there is no handover time built into the shift. Thus, the nurse reporting for the early shift may start work 15 minutes early to allow the night shift nurse to leave on time while...

HANOVER IS A time-honoured tradition and staff on every incoming shift must receive a report of patients' status before commencing care. Some nurses refuse to tend to patients until after a formal handover, illustrating its perceived importance.

The skill to carry out a handover, and provide the relevant information, is not taught during nurse training, but is learnt on the ward. It is not an objective event, relaying only facts, but has a subtle and sometimes unrecognised purpose.

The content and function of handover varies significantly between clinical areas. Some handovers provide an occasion to demonstrate medical knowledge (Lally 1999, Hardey et al 2000, Payne et al 2000), exemplary tidiness (Manias and Street 2000), or comment on personal or irrelevant matters concerning patients and their families (McKenna 1997).

It can allow information to be shared that is relevant to the patient, but not contained in the medical notes, for example personal circumstances or social factors.

Keywords
Communication, handover, patient safety, ward organisation

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ensuring that a handover takes place (McCloughen et al 2008).

In contrast to the medical model of patient description, which values written documentation as a mode of effective communication, nurses continue to communicate orally at handover (Manias and Street 2000). Currie (2002) identified one common feature of all handovers: its quality affects the provision of nursing care in the subsequent shift. For example, providing inaccurate details may jeopardise the patient by allowing mistakes to be made.

Quality appears to be important, but questions arise about whether this involves the content or the structure of the handover and if there are any variables that occur during the handover process, which may affect quality.

Handover has been described as having three functions (Kerr 2002):

- Overt communication functions, through which essential details are transmitted to enable care and assist teaching.
- Covert functions, in which there are ‘psychological, protective and social’ elements.
- Ritual functions, including the culture and routine practices of the nursing handover report and an introduction to the professional language of nursing.

Although ostensibly proposed to hand over the care of patients, research has found that the inter-shift report has other functions. It provides support for team members, fostering ‘group cohesiveness’ (Payne et al 2000) and ‘team-building’ (Hopkinson 2002). The report allows nurses to express their feelings concerning patients and situations, including extreme emotional events, and sometimes functions as a de-briefing session (Cahill 1998, Hopkinson 2002). It may provide an opportunity for safe individual and team reflection (McKenna 1997).

Handover can provide a ‘cathartic benefit’ because the emotional fatigue of a fraught shift can be ‘given away’ and not carried home with the nurse when he or she goes off duty (Philpin 2006). Evans et al (2008) noted that the ‘ritual’ aspect of handover alleviates anxiety.

Another role of handover may be to ‘shape professional identity’ (Payne et al 2000). It can be a testing ground for new nurses during which they are observed and judged by more established colleagues, in the form of ‘peer review’ of the relevance and efficacy of their handover (McKenna 1997). The use of technical language during handover denotes an experienced nurse (Hardey et al 2000), but careful consideration needs to be given to ensure it is adequately explained and allow the opportunity for education of those less experienced or new to the specialty.

Handover is an integral part of the ward culture: students, new members of staff or agency nurses will be socialised into what is acceptable on the ward (Payne et al 2000). Research into the role and format of ward handover illustrates vast differences in acceptable and unacceptable practices between hospitals and wards. Lally (1999) described nurses expressing doubts and concerns about practice, whereas Evans et al (2008) noted that there appeared to be a moratorium on any form of questioning during the handover they observed.

Handover appears to have positive benefits for nurses. They gain motivation and use the experience and information to help them in planning the forthcoming shift (McCloughen et al 2008).

**Location of handover**

Handover occurs in a multitude of settings, depending on ward culture and geography. Bedside handover aims to involve patients in their care, but there are difficulties maintaining patient confidentiality (Cahill 1998). At the bedside, ward curtains are thin and other patients may be able to hear conversations, so nurses may not vocalise sensitive and relevant information for fear they may be overheard. Sometimes the attempt to involve the patient in his or her care is ‘mere tokenism’ (Cahill 1998), as a coterie of nurses gather at the end of the bed ignoring the patient. With unconscious or moribund patients, it is necessary for nurses to talk ‘over them’ because these individuals are unable to have any input.

Although bedside handover occurs in intensive care units (ICU) one may argue that it is not performed to involve the patient because most individuals in ICU tend to be unconscious or heavily sedated. Philpin (2006) found that nurses lowered their voices sufficiently to make it difficult for the awake and alert patient to hear what was being said unless a positive event was being relayed, in which case the nurse might deliberately involve the patient.

During a bedside report the incoming shift has the opportunity to assess the condition of the clinical area, as well as the patient. Some nurses have referred to bedside handover as an ‘examination’ (Manias and Street 2000), suggesting that greater emphasis is placed on the appearance of the bed area than on the
patient’s physical or psychological state. The nurse from the outgoing shift may therefore prioritise defence of his or her actions, for example explaining how busy he or she has been throughout the shift, rather than discussing the condition and treatment of the patient.

Handover may occur in the ward office, promoting confidentiality. This can have both positive and negative effects. The privacy provides opportunities for nurses to make subjective statements about patients (Kelly 2005). Excessive time may be spent describing irrelevant information (Sexton et al 2004), and if effective leadership is absent the report may drift on for longer than is necessary.

Privacy may permit thorough explanation of any or all relevant details concerning the patient and his or her social situation. It may also provide time for the non-patient-specific roles of handover, for example support, cathartic debriefing, peer assessment and motivation, to be deployed. However, the ward office is not necessarily a quiet area free from interruptions. Medical teams may be present, telephones may ring and ancillary or support staff may enter seeking assistance or clarification. Frequent disturbance was the reason cited most often for dissatisfaction with nursing handovers (Meissner et al 2007), although the location of the handovers was not used as a variable in this study.

The ‘complexity and amount of information to be gleaned from a handover report is considerable’ (Cahill 1998) and all the attendees’ attention is required if adequate information is to be transmitted accurately.

**Mode of handover**

Sexton et al (2004) noted four types of handover:

- Bedside.
- Taped.
- Written.
- Real-time oral transmission.

The author has experienced bedside handover and dealt with the perception of ‘examination’ that some nurses associate with this. This type of handover is thorough in ICU; Philpin (2006) noted it can last up to 15 minutes for one patient. However, on a more general ward it would be a swifter procedure and may follow an earlier and confidential report away from the patient (McKenna 1997).

Taped handover was initiated to lessen shift overlap time (Prouse 1995) and thus reduce the burden on financial resources (Burke 1999). Initial concerns regarding the quality of content were refuted because the taped handover honed nurses’ ability to give concise and relevant information (Prouse 1995). However, this is not always the case.

Taped handover also avoids the problems of real-time interruptions (McKenna 1997). If the tape needs to be paused for any reason, the flow of information can readily be started again at a later time, although one author noted a reluctance to stop the tape for any reason (Kerr 2002).

The taped handover lacks nurse-to-nurse interface and thus does not fulfill the social cohesiveness or emotional catharsis functions noted earlier. Hopkinson (2002) suggested that taped handover may undermine important emotional support. This is echoed by Kerr (2002), who believed that a taped handover provides a ‘low level of supportive functions’.

Any questions raised by the handover may remain unanswered. The incoming nurse could consult patient documentation for answers; however, this would negate the time-saving benefits of taped handover. Taped handover does remedy the problems associated with staff on the outgoing shift not being ready for handover when the incoming nurses arrive and subsequent delays to receiving handover.

Written handover is thought to encourage a more formal approach (McKenna 1997). However, as with taped handover, there is a potential lack of opportunity to clarify certain queries. Written handover may also rely on either legible handwriting or computer access, and the amount of information nurses provide can be hard to précis into a manageable format.

In their study on ‘scraps’, the information written down by individual nurses on pieces of paper or small notebooks and carried in their pockets throughout the shift, Hardey et al (2004) suggested that, “nurses use an individual code to describe and detail work that needs completing in the forthcoming shift. A previously written or typed handover template will not necessarily conform to the format preferred by nurses. However, such templates may save time (although McKenna (1997) suggests otherwise) and may prevent knowledge being lost (Pothier et al 2005).”

The use of a card system, or other nursing documents as a form of handover, which request the incoming shift to read through it, remains problematic. People read at different rates, handwriting differs and salient facts can still be omitted. Sexton et al (2004) suggested that, even if nursing documentation was kept ‘up to the minute’, a sufficient amount of time for acquainting oneself with one’s patients is not available at the beginning of a shift.

Face-to-face handover from one outgoing nurse to the whole incoming team—the ‘global’ nursing handover report (Manias and Street 2000)—may be followed by an individual-to-team or
even nurse-to-nurse report, possibly at the bedside. In a Norwegian study investigating the benefits of face-to-face handovers, Engesmo and Tjora (2006) reported: ‘Pertinent information was not an objective measure and differed from nurse to nurse, depending on general experience, specific patient knowledge and individual preferences.’

An oral report system can be sufficiently flexible to accommodate the experience and ability of attendees. It may also permit a depth of subtlety that may not be managed in a written or taped handover. Meissner et al (2007) noted that nurses ‘are more likely to discuss psychosocial aspects of care’ during oral reports.

The length of oral handover may be problematic in that it removes a large amount of staff from patient care for between 15 and 90 minutes (McKenna 1997). Clemow (2006) found that often the whole incoming shift and at least one nurse from the outgoing shift attends oral handover. This could be perceived as a poor use of highly skilled resources, but as the author hopes to demonstrate, the ward report is an important event, crucial to the wellbeing of the patient.

A lengthy handover could induce boredom (Cahill 1998) and may lessen time available after handover in which to complete essential tasks (McKenna 1997). The problem of removing staff from the ward or unit is exacerbated if the outgoing shift is not ready to give handover – Sexton et al (2004) noted delays in attendance of up to seven minutes—or if the ward culture allows other events to take precedence. The author does not suggest that nurses should not react to emergencies that occur during or immediately before handover. However, the routine acceptance of laxness in outgoing staff reading themselves for handover, or tardiness among incoming staff, causes delay and frustration to those waiting to receive the nursing handover report.

**Structure of handover**

Face-to-face handover, although lacking in ‘formal structure’ (Sexton et al 2004), still has essential aspects. There is a ‘settling in time’, a preamble in which nurses talk about their private lives and prepare for the nursing handover report. This could take as long as ten minutes (Lally 1999). Evans et al (2008) suggested that this time promotes the social cohesion of staff. This social aspect could also continue, if time allows, after the bulk of the formal report has taken place (Lally 1999). However, a lack of specific structure can result in confusion (Sexton et al 2004).

The passing on of patient-related information forms the body of the handover, although this can also be subdivided into logistic details (name, age, diagnosis), followed by details of the nursing process, interdisciplinary involvement and psychosocial elements of care (Lally 1999). Evans et al (2008) commented on the use of a concluding remark to pinpoint when the patient-related information transfer has come to an end, allowing general or organisational communication to occur.

The content of the handover also varies. McCloughlen et al (2008) stated that ‘a lack of consistency in time, person and content was identified as having a negative impact on the quality of handovers’.

The personal style of the nurse undertaking the handover may emphasise different aspects of patient care and may give more credence to personal details or life events of the patient. These may be relevant. They may affect discharge plans or even the patient’s physical or mental wellbeing. Some nurses report on ‘their own activities over the shift, rather than providing patient-centred information’ (McKenna 1997). Others limit their handover to physical events that have occurred and follow a medical model of patient description.

**Limitations of handover**

The aim of handover is to pass information from one shift to another to ensure effective and safe patient care. The change-of-shift report also fulfils other staff-related functions, including teaching and inter-personal support. On wards where non-interactive handovers take place, some of this staff support function may be lost. This may be problematic because the report process appears to have benefits for nursing staff. More research needs to be conducted on the gains and losses of handover for nursing staff.

The location of handover delineates a certain extent on what information will be passed. For example, an office far out of sight of patients will allow detailed information exchange, but may also allow subjective matters concerning the patient to be discussed. A handover that is constantly interrupted is also difficult, as a huge amount of complex and sometimes subtle information is being shared and may be lost because of the disruption.

Attempts to save time and therefore financial resources have led some areas to try taped handovers. This has been again not without problems although it is quicker than some real time handovers. Face-to-face reports may provide an opportunity for questioning, yet some ward cultures discourage questioning at all during the process. The content of the information transferred during handover differs
from ward to ward, and it may not provide the incoming shift with the accurate information nurses need to care for the patient effectively.

Improving handover

Meissner et al (2007) suggested that leadership may be the one quality needed to improve handover. For example, the ward manager could ensure that staff are ready to handover at the correct time, thus recognising the importance of their colleagues’ time and their own clinical input. Organising staff meal breaks at times other than at handover, and designating a nurse to field enquiries and direct ancillary staff to prevent interruptions, are other examples.

Lack of relevant, clear information to help plan the care for the oncoming shift can be problematic, and it can be difficult to glean relevant details if the handover is unstructured. Some authors suggest that guidelines or teaching initiatives should prescribe what is needed for an effective handover (McKenna 1997, Cahill 1998, Currie 2002, Sexton et al 2004, McCloughen et al 2008).

A clear expectation of what is to be dealt with during handover and the manner of conveying that information can help to produce effective transfer of knowledge. A clear format could be devised for each ward, detailing what a report should consist of. Perhaps each ward or unit could decide on the necessary input, based on their area of expertise and client base.

This is not to suggest that additional information should not be included if it is considered important and relevant to patient care or outcome. It may be that the format would differ from ward to ward, area to area, and speciality to specialty, but it is important to remember that nurses working in all these settings have a common aim: the wellbeing of patients in their care. The existence of prescribed expectations would give a much needed framework with which nurses can report to each other and pass on relevant information.

Conclusion

Nurses are not taught during training how to give handovers. This activity is learned on the wards from observing mentors and peers, first as students and, later, when in a post-qualification position. Nurses learn to fit in with the ward culture, which may mean that the importance of handover as a social and emotional support system and teaching tool, and for communicating patient details and nursing care, is not recognised. Too often the importance of handover is ignored to the detriment of colleagues and patients.

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