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Systematic review of the intervention used to improve the intra-hospital handover process quality and safety among nurses

(A systematised review)

(Research)

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Abstract

Clinical handover is a permanently or temporarily exchange of patient care between various health professionals. Number of researchers show a causal link between negative events and poor communication during handover, supporting greater recognition of the role that handover plays in patient care quality and safety.

The PEO framework was used to formulate the research question, and the main key term was used in a database search that included Medline, CINAHL databases, British Nursing Index, National Institute for Health and Care Excellence (NICE), as well as studies from the Cochrane Collaboration, Science Direct, and the Education Resources Information Centre (ERIC) from 2007 to 2017. This evaluation includes 12 studies that were both eligible and relevant.

The nurse shift handover was discovered to be a vital component of nursing while delivering care to patients, along with a multidimensional information transfer procedure and the enhancement of patient safety results. High levels of care can only be delivered by making high-quality information available. When the handover procedure is standardized, there is less patient information loss and an increase in the efficacy of communication practice at the same time.

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The goal of this systematic review is to determine the most effective intra-hospital handover technique or tool that nurses can use, as well as to fill a gap in the literature in which there appears to be no other systematic review that analyzes handover models in terms of patient care quality and safety.

Keywords: (Clinical handover, Nursing, Patient care, Handover procedure)

1. Introduction

Bhabra, Mackeith, Monteiro, and Pothier (2007 asserted that the primary objective of this systematic review is to determine the most effective intra-hospital handover technique or tool that nurses can use. As well as to fill a gap in the literature in which there appears to be no other systematic review that analyzes handover models in terms of patient care quality and safety. However, Jeffcott, Ibrahim, and Cameron (2009) explained that an increasing number of academics believe that the existing handover method employed in a variety of healthcare settings is uneven and unsatisfactory. As a result, as reported by Jorm, White, and Kaneen (2009), many handover-oriented efforts have been implemented in recent years to improve patient safety and care, with global research demonstrating that this is a key issue.

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One such program is the World Health Organization's 2006 "High 5s" project, in which handovers are one of the five primary foci across the initiative's five-year timeframe (Haugen et al., 2013). The effort is a collaboration between the WHO Collaborating Centre for Patient Safety, the WHO World Alliance for Patient Safety, and the Commonwealth Fund. In addition, in 2007, the Joint Commission on Accreditation and Healthcare Organizations added handover communication as one of its National Patient Safety Goals.

While Manser and Foster (2011) remark that other high-risk industries have been researched in terms of the impact of human behavior during the handover process, there are relatively few systematic review studies on patient handover in the healthcare setting, with this approach only being explored in recent years. Patterson and Wears (2010) agree, pointing out that a growing number of review publications have just recently begun to emphasize patient safety, with a focus on patient handover as a basic procedure.

Apker et al. (2010) emphasis on hospital handovers between physicians, Riesenberg et al. (2009) focus on handover between nurses, while others focus on perioperative care handovers and handovers for specific clinical contexts.

The question to be addressed in all healthcare settings where handovers are employed is: what is the most effective intra-hospital handover strategy or instrument that nurses can use? As a result, the goal of this

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systematic review research is to address this topic while also filling a gap in the literature, as there appears to be no other systematic review that analyzes handover models in terms of patient care quality and safety.

1.1 Research Problem & Questions

This part of research diagnoses the research problem and the main questions that will be answered through the theoretical framework of research:

1.1.1 Research Problem

According to Bloom (2002), the Institute of Medicine (IOM) underlined the necessity of handovers in ensuring that accurate patient care information exists and is available when needed in its 2001 study, "Crossing the Quality Chasm."

In their hospital survey study, Westat et al. (2008) found that crucial information on patient care is frequently misplaced when patients are transferred to different departments or when staff ends their shifts. The link between bad events in the hospital context and poor communication among workers is well acknowledged and studied, especially considering the higher risk of error involved.

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This systematic review stresses patient care consistency in the hospital context by focusing on handover between nursing personnel. Nursing handover was chosen as the research topic due to the critical role that nurses play in the healthcare environment, with Mess am (2009) noting that nurses provide 24/7, round-the-clock care and IOM (2010) emphasizing their involvement in multidisciplinary communication and complex patient care coordination. This necessitates nurses having complete access to each patient's care plan, with handovers often occurring twice every shift and three times per day. Furthermore, due of the high number of nurses working part-time hours, handovers frequently occur between a significant number of different nurses.

Over the last ten years, there has been increased push for interventions to be implemented in order to improve the handover process. According to Bost et al. (2010), the established interventions are all created with a reasonably common goal in mind: to raise joint understanding and improve communication while ensuring that critical patient information is available at all times. Given this, clarification on what constitutes appropriate handover in the nursing environment is required.

1.1.2 Research Questions

The search questions centered on discovering interventions designed to improve hospital handover safety and/or quality.

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Many researchers, according to Bettany-Saltikov (2012), advise using the patient/population, exposure, and outcome (PEO) model to focus search questions for review publications. Furthermore, Doody and Bailey (2016) state that one of the primary advantages of the PEO model is that it permits population sizes to expand across different categories. Second, it enables for the inclusion of all essential material in the review. The PEO technique was used in the current review study for these reasons.

The PEO framework enables the review question to be specified, defined, and associated with a specific issue or topic, guaranteeing that the review may provide accurate, comprehensive description.

1.2 Research Significance & Definitions

This part of research investigating the importance of this research, besides the main terms that are mentioned:

1.2.1 Research Significance

Because of the established importance of the handover process in inpatient care, various hospitals and other institutions to improve handover quality have undertaken an increasing number of programs and efforts. Because the number of research publications focusing on this topic grows each year, it should be feasible to acquire a solid

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understanding of how beneficial these programs are in avoiding adverse occurrences and ensuring consistent patient care. Given that the WHO (2007), along with other governmental organizations, has advocated for the implementation of such treatments, it is critical that relevant information is made available to support policy development and decision-making on this subject.

Without adequate evidence of effectiveness, subsequent efforts may face resistance from healthcare professionals, and critical resources may be misallocated. As a result, the purpose of this research is to determine which handover model or technique is the most effective, based on evidence from studies that have been published, examined, and demonstrated to be of the highest quality standards.

1.2.2 Research Definitions

Thurgood (1995) observes that while there is no unified definition of handover in the available literature, most agree that the primary goal of handover is to ensure continuity in inpatient care. Cohen and Hilligoss (2010) go on to say that, the handover process varies from other methods of patient-centered communication in that it sets the recipient of the handover information in charge of patient happiness, safety, and care quality.

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According to Kassean and Jagoo (2005), handover between nurses is most commonly done at the patient's bedside, using verbal communication, nonverbal information, and recorded information. According to Arora et al. (2009), bedside handover takes place next to the patient's hospital bed, allowing nurses to communicate directly with patients and patients to become actively involved in the exchange of information regarding their own care. According to Caruso (2007), verbal handovers are often performed in the staff office, with one nurse in charge of a large number of patients for whom he or she must offer handovers so that other nurses are properly informed.

According to Ye, Taylor, Knott, Dent, and MacBean (2007), nonverbal handover occurs within the staff office and can include documentation such as nursing care plans, observation or prescription charts, and the patient's health record, which the nurse reads. Lastly, as Dowding (2001) describes, recorded information is given in the staff office, with the nurse on duty recording all patient information into tape and providing it for arriving nurses to listen to when they begin their shift.

1.3 Research Objectives

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It is expected that the study's goal is to assess the efficacy of nursing handover improvement initiatives in the hospital context; the following two research objectives have been developed**:**

- Identify which handover model or process gives the best patient results in the hospital context, as well as which models seem to provide the best outcomes for nurses. Initiatives developed with the goal of increasing the safety and/or quality of the nurse handover procedure in the hospital setting are explicitly examined here.

- To examine efforts developed with the goal of improving information interchange during handover. Besides, compliance, clinical results, time-effectiveness, and nurse satisfaction.

2. Review of the literature

This review of the literature provides a critical examination of the research arguments offered in many scholarly articles on the current study's topic. The chosen scholarly work sheds light on investigating a systematic review of the intervention used to improve the intra-hospital handover process quality and safety among nurses.

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2.1 A Thorough Examination of the Included Studies

This part of the current research refers to a comprehensive examination of the studies included in the thesis, and they were analyzed as follows:

Many studies in nursing aim to develop evidence-based practice while also conducting rigorous assessments of past research (Wood & Kerr, 2010). The goal of this evaluation is to address the practice of nurses during handovers.

The author planned to restrict the literature to publications published since 2012 however, this proved too limiting. Although some publications met this requirement, they were primarily concerned with patient and nurse satisfaction rather than patient safety. As a result, it was decided to broaden the search parameters beyond five years. One advantage of this is that it took up on earlier, seminal work.

Australia (n=5), Singapore (n=1), the United Kingdom (UK) (n=1), and the United States of America (USA) (n=5) were the nations of publishing and the number of articles published in each. Having papers published all around the world gives access to a broader range of nurse handover practices, allowing for a more comprehensive knowledge of the process. As a result, the purpose of this review is to seek broad answers and

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foster a better knowledge of nursing handovers in industrialized countries.

Each of the studies included in the evaluation clearly states the study's objectives and research issues. Johnson et al., 2016; Kerr et al., 2016; Sand-Jecklin & Sherman (2013), and Sand-Jecklin & Sherman (2014) sought to analyze the impact of a new handover system on nurses' handover practices. Klim et al. (2013), Poh et al. (2013), Randell et al. (2011), and Staggers & Jennings (2009), on either side, concentrated on shift handover procedures and how they were carried out, meanwhile Bradley & Mott (2014), Chaboyer et al. (2010), Laws & Amato (2010), and Maxson et al. (2012) define preconceptions, procedures, and the framework of bedside handovers.

Bradley and Mott (2014), Johnson et al. (2016), and Klim et al. (2016) conduct mixed methods research that collect both quantitative and qualitative data (2013). The quantitative component consists of close-end information that is easily suited to statistical analysis and outcomes that be numerically or graphically presented. In contrast, qualitative data is subjective and open-ended by definition; it is intended to capture participants' perceptions and ideas and enables observations to be evaluated.

Mixed methods strategies are useful because they can provide a balance to the qualitative and quantitative strands of discovery, which are both erroneous in their own way (Axinn & Pearce, 2006). According to Nuttin

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(2014), qualitative research is subjective and not easily generalizable to populations; also, it is prone to bias and is unsuitable for statistical analysis. Quantitative research, on the other hand, fails to account for the surroundings and contexts that can affect data. The mixed-methods approach gives a way to compensate for these shortcomings (Terrell, 2012).

The papers covered in this review used experimental methodologies. Using a quasi-experimental method, the researchers can investigate the impact of a change in a structure or process on outcomes while controlling for other variables (Campbell & Stanley, 2015). This approach lends more credibility to researchers' findings that differences in results (effects) are directly tied to changes in handover structures and processes (cause).

Eight of the studies employed questionnaires to survey respondents, with Johnson et al. (2016), Kerr et al. (2016), Sand-Jecklin and Sherman (2013), and Sand-Jecklin and Sherman (2014) using trustworthy and valid questions. Johnson et al. (2016) used the modified Bradley Clinical Handover Survey (Bradley, 2010) to assess changes in nurse satisfaction. The survey had good internal consistency. Kerr et al. (2016) used O'Connell, Macdonald, and Kelly's Clinical Handover Staff Survey (2008).

Nevertheless, Sand-Jecklin and Sherman's two investigations (2013 and 2014) used two different survey techniques. The first was an adaption of the Patient Views on Nursing Care questionnaire (Larrabee, Engle, &

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Tolley, 1995). Staff nurses, nursing managers, and a questionnaire development specialist reviewed the amended questionnaire.

The instrument's Cronbach's alpha was 0.96, with inter-item correlations ranging from 0.49 to 0.80, indicating that the items measured shared associated but non-identical variables. The Nursing Assessment of Shift Report, developed based on literature reviews, was the second instrument utilized by Larrabee et al. (2003). The tool's reliability was 0.90, although inter-item correlations ranged from 0.20 to 0.71.

When the data from the research considered in this analysis were combined, it resulted in a corpus of information acquired from 945 nurses and 665 patients in 790 handovers. Except for the Laws and Amato (2010) study, which failed to record the sample size and sampling method, all other studies included this information. The sample size for nurses ranged from 33 (Randell et al., 2011) to 258 (Randell et al., 2011). (Johnson et al., 2016).

Five of the six studies used appropriate data collection methods; despite the fact that the sample was neither random nor representative of the overall population (either convenience or purposeful sampling approaches were used). The majority of the studies had a tiny sample size with no reason or rationale for getting at that sample size; they also fail to adequately disclose recruitment tactics.

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None of these studies clearly illustrates the interaction between participants and research. Two of the research did not include an ethical approval statement, but the most common design and sample flaw among the six quantitative studies is the use of a descriptive design. This makes interpreting causes and effects difficult (Taylor, 1999). Despite these studies' flaws, the data analysis methodologies were detailed clearly, yielding useful results and recommendations.

The most common flaw in the experimental trials in this analysis was the lack of reason for the researchers to recruit or analyze the number of people that they did. There is uncertainty about the sample size's suitability for detecting relationships between variables or providing validity for the measured outcomes. In none of these investigations was the sampling size established by a sufficient power calculation.

Four of the research acknowledged the reliability and validity of the data collection methods and means. According to Cronbach's alpha, the reliability of the questionnaires employed in three investigations was rated adequate. This is a popular statistical metric of internal consistency (score > 0.7). (Cortina, 1993). Only two trials recorded response rates, both of which were less than 60%, which is considered low.

All eight research relied on self-reported data, and none employed data gathered objectively from an observer. This means that the trustworthiness of the responses may be jeopardized if the survey items are misconstrued by researchers. Similarly, individuals' interpretations

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and understandings of the significance of questions differ (Austin, Deary, Gibson, McGregor, & Dent, 1998)

2.2 Literature Research Findings

As for this part of the research, it refers to the results of the studies mentioned above:

Only five of the twelve research studies produced statistically meaningful findings. Among these, Bradley and Mott's (2012) study looked at bedside handover at three South African hospitals. For 48 RNS, a seven-point Likert scale was used as part of a 19-question questionnaire and ethnographic interview (self-chosen).

These questions attempted to measure nurses' satisfaction with the handover process in terms of the frequency of events (including medication errors, burns, falls, and skin injuries), as well as handover time both before and after the introduction of standardized handover methods.

Maxson et al. (2012) conducted a study to see if bedside nurse handover improved patient satisfaction as well as communication within the medical team. The study was quasi-experimental, with a convenience sample of 60 patients, 30 before and 30 after the practice change. Everyone on the nursing staff was invited to take part. Before and one

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month after the practice modification, both patients and staff were given self-designed surveys.

Questions were utilized among nurses to assess communicative efficacy during handover, medication reconciliation, and changes in accountability, workload prioritizing, and capacity to communicate with other healthcare providers after turnover.

The patient survey consisted of five questions, with the question about whether the patient was given information about the daily care plan yielding significant results (p=0.02). In the survey of nurses, all but one item provided statistically significant results (p0.05), namely if Shift reports were useful for prioritizing nurses' responsibilities (p=0.06).

The researchers concluded that handover by the bedside had a good effect on nurses and patients due to improved communication and staff awareness of this. Furthermore, the handover discourse was found to have a good effect on patients' errors, lowering them because of improved medical reconciliation and communication.

Two hundreds and twelve handover processes were examined, and the findings pre- and post-change implementation revealed a substantial rate of compliance improvement across the four criteria. There had been a 49 percent increase in the number of standardized documentation used throughout nursing shifts; a 74 percent increase in the complicit use of correct inpatient identification at the beginning of every case report; a

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31 percent increase in correct patient history handling procedures; and an 18 percent increase in detailed observation of patients by nurses. The PACE program was used to audit and convert data into percentages, with no additional information or statistics included in the study.

A West Virginia University research study (Sand-Jecklin and Sherman, 2013) implemented a change in practice from an exclusively recorded handover report to one that contained short recording and a bedside aspect, in a blended version of handover. Through instructional workshops and informational handouts, nurses were given a description of how they should behave during the handover process.

The survey's post-implementation findings were as follows: a) "ensure that I was clear as to who my nurse was" (p=0.29); b) "be incorporated into a discourse regarding shift reports" (p=0.17); and c) "convey significant information between and throughout shifts" (p=0.16). When compared to the pre-implementation survey, they showed statistically significant differences. As a result, perceptions of bedside report nurses were assessed both before and after the procedures were introduced.

The following aspects were discovered to have significant improvements: a) was an effective communicative means (p0.001). b) Was a proficient means of communication (p0.001). c) Was relatively stress-free (p0.001). d) Aided in the prevention of care delays for the patient (p=0.025). e) Was completed in a reasonable period (p0.001); f) ensured

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accountability (p=0.003); and finally, g) encouraged and promoted patient involvement in their care.

During the preceding month, prior to the adoption of the integrated bedside handover process, and three months following implementation, there was a 50% decrease in medication mistakes and a 35% decrease in inpatient falls. Although not statistically significant, the clinical significance of these findings should not be overlooked.

There was some discrepancy in the definitions of "handovers" utilized in the research included in this evaluation. Poh et al. (2013) defined the handover process as "the temporary/permanent transfer of processional accountability concerning every element or per ocular element in the care of a patient to someone else." Chaboyer et al. used the term "transfer of accountability from one person or group to another about patient care" instead (2010).

Some authors, including Maxson et al. (2012), Laws et al. (2010), and Sand-Jecklin and Sherman, did not provide a precise definition (2013). Maxon et al. (2012), on the other hand, provided an explanation of the procedures involved in handover in order to expand and explain the handover process and the functions involved. This allows for patient safety, continuity of treatment, and crucial and necessary patient care information.

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Notwithstanding of such variances in definition, there were three major thematic trends observed in recommendations for better practice in the publications reviewed. These were as follows: 1) standardize the procedure and substance of handovers; 2) incorporate the bedside component; and 3) improve patient safety outcomes by modifying nursing handover practice.

According to Freytag and Carroll, a standardized handover procedure is one in which patient care information is delivered in an efficient and uniform manner between two separate nurses or healthcare practitioners (2011). Each study was evaluated based on a specific handover process and the use of a tool during handoff. There was evidence of standard material during the handover process, which was then used in 5 separate publications.

Despite the benefits of an auxiliary electronic record, Johnson et al. (2012) and Johnson et al. (2016) argue that continued and consistent ICCCO use is disputed. There have been reports of nurses using alternate models, but the model is not widely used. According to Johnson et al., its efficacy and capacity for transferability between specialties remain contested and ambiguous due to its limited utilization in surgical and medical wards (2012; 2016)

Four of the twelve studies included in this review (Bradley & Mott, 2014; Chaboyer et al., 2010; Kerr et al., 2016; Laws & Amato, 2010) describe findings on the bedside handover component. Bradley and Mott (2014)

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discovered that patients appreciated nurses who chose to spend time with them. Their study found that staff members who knew their patients' names made their patients feel more secure that they were involved in the care process.

They also discovered that the verbal bedside handover procedure gave patients the impression that they could ask the nurse about their treatment, management goals, and add or contribute elements to their own plan of care. Finally, Bradley and Mott (2014) discovered that the bedside approach facilitated a more holistic and comprehensive treatment plan, and patients who were more vulnerable, uneducated, or uninvolved felt more empowered.

According to this study, one notable difference between the bedside technique and other approaches is that nurse's only gain knowledge about their assigned patients, which may limit the nurses' ability to aid one other when dealing with patients. Sensitive conversations were held away from the patient, providing secrecy and privacy. Nurses were in charge of deciding what was sensitive and what was not, but patients had no input in the matter.

According to Laws and Amato (2010), nurse bedside reporting boosted patient safety and made it easier for patients to discuss their care. Furthermore, nurses believed that such a bedside handover method made employees more accountable, resulting in a more effective nursing team. Written responses from nurses suggested that they believed the

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new reporting method provided them with critical information, allowing them to care for patients more efficiently.

Certain areas for improvement were also identified, for example, the morning and evening shifts were discovered to gain the most from handovers inside the new system. Additionally, nightshift nurses benefited from the new sheet rather than speaking to avoid disturbing patients who were sleeping. Sensitive concerns and discussions necessitated a brief report, which was launched on an as-needed basis. Nurses were nonetheless concerned about patient confidentiality, despite the fact that some topics and discussions about them are permitted under nursing rules.

Following the standardization of the handover process, practice suggestions and recommendations offered in the literature cited herein had a positive influence. As a result, negative outcomes were minimized, as were complications for patients.

The investigations in this literature review discovered that the nurse shift handover, together with a multidimensional informational transfer procedure and the enhancement of patient safety outcomes, is a key component of nursing while delivering care to patients. High levels of care can only be delivered by making high quality, readily available information available. When the handover procedure is standardized,

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there is less patient information loss and an increase in the efficacy of communication practice at the same time.

Using mnemonics in conjunction with a standardized handover template helps ensure that error-checking processes and informational erroneousness or redundancies are enforced. Transferring to the bedside aids team safety evaluation and, as a result, patient safety, as well as patient and familial involvement in the patient's care, the patient's degree of satisfaction, and patient safety.

3. Research Methodology

The research issue was established first, followed by the systematic identification of relevant works. Then, appropriate studies were methodically chosen before being evaluated for quality. Following that, data was obtained before being examined, with the results being described in this thesis. The total sample for the review papers were that they had to be published in English, be human research, and have been published between 2007 and 2017. The search yielded 862 items using these criteria. These publications were then filtered to remove any studies that were not explicitly about the nursing profession.

Because the retrieved articles presented an excessively wide reference base, it was important to restrict the number of publications such that

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only the most relevant and noteworthy studies were included. Hersh et al. (2015) note that many researchers recommend such an approach in order to refine the retrieved articles to include just the most relevant and important. The section that follows goes through the inclusion and exclusion criteria that were used for the current review study in greater depth.

Data extraction can be influenced by inaccuracy and bias, as well as subjectivity. As a result, it is critical that data extraction be carried out in a systematic manner. To achieve this in the current review, the author created a table with a summary of the 12 selected research papers (Please see the date traction sheet appendix 1). The systematic review structure was examined and provided. As well as an outline of the differences between a systematic review and the one employed in this dissertation. Each stage of completing this type of review was then detailed, including the review technique, search strategy, selection criteria, data extraction, and analytical approaches.

4. Research Discussion& Limitations

This part will outline the methodological quality of the included studies and present the findings of the articles in the form of narrative analysis. Besides the limitations of the research:

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4.1 Research Discussion

Every previous study reviewed herein finds that when patients are consulted or requested to provide feedback regarding their own healthcare, they appreciate it; this did not occur in the closed-door handover procedure. Bedside handover is beneficial in terms of its contributions to patient-centered care (Tobiano, Bucknall, Marshall, Guinane, & Chaboyer, 2016). It can be determined that the closed-door office technique of handover is less patient-centered than the bedside handover method.

The findings of this systematic review emphasize the importance of formal training sessions and education for nurses before effective and structured handovers can be fully implemented, as well as the means to address the numerous handover inconsistencies that exist among staff; they advocate for more efficient documentation (Halm, 2013; Meth et al., 2013; Anderson et al., 2015). Thus according Spooner et al. (2013), extra education and training, in furthermore to the use of handover models, can potentially increase the efficacy of handovers by encouraging nursing staff to administer and adhere to handover procedure and more successfully administer standardization during this whole procedure.

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4.2 Research Limitations

This review has certain limitations, which will be discussed in this section. First, due to time limits, grey literature and yet-to-be-published material were not used for this review. Because the review period spanned a decade, from 2007 to 2017, earlier research and other work had to be excluded. Furthermore, due to the author's linguistic capacity, only English language studies were employed, and thus other studies from regions other than the English-speaking world may have been overlooked. The inclusion criteria therefore constitute a further constraint to this review. Furthermore, the initial database's size hampered the review. It is possible that specific papers were not retrieved despite the keyword search, even though the author was careful and aware while deciding which research to utilize.

5. Conclusion & Recommendations

An effective handover model can boost the efficacy of the handover process by ensuring that patient-centered care is personalized to the patient. Model standardization across healthcare institutions and organizations that helps improve the handover process and can simply be transferred from one specialization to another is the best choice for

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utilization and implementation. Only the SBAR model and its variations have been effectively adopted in a variety of specialized disciplines, where they have been altered and amended for bedside handovers and nurse communication.

Structured processes increase communication skills, information accuracy, and critical thinking, and they can motivate nursing staff to provide evidence-based healthcare while keeping patient safety and error prevention in mind.

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