Patients’ Views of Bedside Handover in Hospital: A Literature Review
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Special thanks go to all my graduate friends, especially X, X and X, for all their assistance; to my friends X and X, who have always been there. Many thanks also to the X and X for their support.

Finally, I wish to express her love and gratitude to my beloved families, for their understanding and endless love, throughout my studies.
Declaration

I, X, X, X, hereby declare that the work titled Patients’ Views of Bedside Handover in Hospital: A Literature Review is my original work. I have not copied from any other students’ work or from any other sources except where due reference or acknowledgement is made explicitly in the text, nor has any part been written for me by another person.

____________________  ______________________
Date submitted        X
Abstract

**Aim of study:** to review the research literature on patients’ perceptions of bedside handover.

**Background:** In 2014, the Irish Department of Health launched new guidelines recommending that, in maternity hospitals, handover be moved to the bedside so as to involve patients. Similar guidelines are expected for other healthcare settings. It is important to know if patients are prepared to become partners in their care by being involved them in the handover process.

**Search strategy:** The following online databases were searched: AMED, CINAHL, the Cochrane Library, MEDLINE and PUBMED, using key terms: handover, handovers, hand-over, hand-overs, handoff, handoffs, "shift report", "shift reports", "change of shift", "change of shifts", bedside, bedsides, perceptions, perception, idea, ideas, sense, senses, view, views, experience, experiences, attitude, attitudes, patient, patients, client and clients. Hand searches, on the reference list of articles, were performed to ensure articles were not missed. A total of 23 articles were used in the literature review, from the USA, England, Australia, Ireland, Canada and Mauritius. The literature was critically analysed and discussed under four themes.

**Main Findings:** **Being Informed:** Bedside handover gives the patient a sense of control over decision-making; nurses share information with patients, reducing anxieties and improving the nurse-patient relationship. Barriers in communication between nurses and patients, such as medical jargon, need to be reduced. **Being Involved:** Patients want to be involved in their care, but different patients want different levels of involvement. Bedside handover ensures more patient-centred care, bringing the patient to the centre of attention. **Continuity of care:** Patients can witness information being passed on; not only clinical information, but also about the patient’s personal needs, thus improving practice and helping nurses to obtain better information about patient conditions and needs. **Confidentiality:** Patients agreed that positive aspects of bedside handover outweighed concerns about confidentiality, but that sensitive information should be managed.

**Conclusion:** The literature showed a consensus about the desire of patients to be informed about their care, but the way that the information is shared needs to be tailored by nurses. The type of information and the ward environment (e.g. bed
spaces) need to be considered during handover, to enhance patient satisfaction. Confidentiality issues were outweighed by the advantages that bedside handover brings to patients. Patients agreed that nurses are sharing information on patient care between shifts, thus ensuring continuity of care.

**Recommendations:** Nursing bedside handover should be implemented to involve patients in decisions about their care, to enhance patient-centred care, and to improve patients’ outcomes.
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Introduction

In acute hospitals, it is normal practice that nurses meet when starting and finishing shifts, to discuss information about patients, to ensure continuity of care and to transfer responsibility from one shift to the next (Greaves 1999). This process, called handover, usually happens away from patients in the nurses’ station or in an office (National Health Service 2004).

Smeulers et al. (2014) identify several styles of handover, which are summarised in Table 1 below.

<table>
<thead>
<tr>
<th>Style</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal</td>
<td>Nurses exchange information about the patients verbally.</td>
</tr>
<tr>
<td>Non-verbal</td>
<td>Nurses read patient medical and nurses notes (observation charts, prescription charts, care plans).</td>
</tr>
<tr>
<td>Taped</td>
<td>Nurses record information onto an audiotape for the next shift nurse to listen to.</td>
</tr>
<tr>
<td>Bedside</td>
<td>Nurses and patient talk face-to-face, which allows the patient to interact and be central to the process.</td>
</tr>
</tbody>
</table>

*Table 1: Different approaches to handover (Smeulers et al. 2014)*

The Irish Health Information and Quality Authority (HIQA 2013) recommends the elaboration of standards and guidelines for handover both to improve communication and for patient safety. The importance of accurate, up-to-date and appropriate information being shared between healthcare employees is also highlighted in the National Standards for Safer Better Healthcare (HIQA 2012).

In 2014, the National Clinical Guideline Number 5 for Communication (Clinical Handover) in Maternity Services was launched to guide standardization, to improve safety and quality, and to reduce the costs of maternity care in Ireland (DoH 2014). The guideline recommends patient and carer involvement in the handover process (Recommendation 25) to ensure that information about care, condition and treatment are given to them (DoH 2014). The recommendation is for handover to be at the bedside, where information can be verified and questioned by patients. This guideline is specifically for maternity services. A similar guideline has yet to be produced for acute care, but since HIQA (2012) emphasises the
importance of person-centred care, healthcare professionals in acute-care settings should expect similar guidelines in the future.

The author’s interest in this topic originated when working in a large teaching hospital in Ireland, where she experienced different approaches to handover and noticed that patients were not being informed about their care and there was a lack of connection between patients and nurses. The new guidelines and research into handover styles concluded that handover at the bedside is the best option to keep patients informed about their care (DoH 2014).

Bedside handover benefits patients by keeping them informed and enabling them to know who is caring for them (Cahill 1998, Chaboyer et al. 2009). Bedside handover also empowers patients within the healthcare process (Cahill 1998, Chaboyer et al. 2009) and gives them opportunities to speak with nurses (Kelly 2005, Chaboyer et al. 2009). Informed patients are more likely to follow medical instruction and be less anxious (Anderson & Mangino 2006, Grant & Colello 2009).

The purpose of this literature review is to evaluate the research on bedside handover from the patient’s perspective. Healthcare systems are moving away from the traditional paternalistic approach towards the nurse-patient therapeutic relationship. If patients are disposed to be partners in their care, understanding their point of view on innovative practices such as bedside handover is an important factor in facilitating change (Detmer et al. 2003, Pullen & Mathias 2010). The question to be answered is: “What are patients' perceptions of bedside handover in the acute hospital setting?”
Search Strategy and Results

A comprehensive search of the literature was conducted in January 2015 (Appendix 1 & 2) concerning patients’ perceptions of bedside handover. The evidence was obtained from the databases AMED, CINAHL, the Cochrane Library, MEDLINE and PUBMED, using, individually or in combination, the terms: handover OR handovers OR hand-over OR hand-overs OR handoff OR handoffs OR "shift report" OR "shift reports" OR "change of shift" OR "change of shifts" AND bedside OR bedsides AND perceptions OR perception OR idea OR ideas OR sense OR senses OR view OR views OR experience OR experiences OR attitude OR attitudes AND patient OR patients OR client OR clients.

Inclusion criteria:

- Peer-reviewed
- English language
- Full text
- 2005 onwards
- Patients

Exclusion criteria:

- Not peer-reviewed
- Unpublished research
- Healthcare professionals

Three articles that fell outside the time parameters have been included because they are seminal studies on the topic of this literature review, having appeared frequently on the reference lists of the more current articles.

Using the criteria listed above, 87 articles were found. Each article was analysed by title and abstract. A total of 19 articles relevant to patients’ perceptions of bedside handover were identified by this process. Hand searches were also performed on the reference list of each of these articles, and four more articles were obtained. The 23 articles were evaluated and appraised, for quality and robustness, using the Generic Framework Critical Appraisal (X & X 2013). Although some articles were found to have limitations, all were included in this literature review (Appendix 3 & 4).
Thirteen of the studies were intervention studies; five were descriptive qualitative; one was descriptive quantitative, two were descriptive case studies, and two were literature reviews. Studies were conducted in the following countries: United States of America, England, Australia, Ireland, Canada and Mauritius, showing that bedside handover is a topic of international interest. Apart from Mauritius, the countries cited above are included in the list of the world’s 50 best health systems (World Health Organization 2000), which is based on a World Health Organization (WHO) evaluation of national healthcare systems according to the criteria of quality, patient-centred care and safety.

Four themes emerged from analysis of the studies: being informed; being involved; continuity of care, and confidentiality. The literature will be discussed under each theme in turn.
1. Being Informed

Under this theme, patients' views on the value of being informed about their care during bedside handover will be explored. Of the 19 studies reviewed under this theme, the majority showed that patients would like to be informed about their care as a means of reducing their anxieties and to give them a sense of control over decision-making. It is important to note that five studies showed that patients' perceptions can be different depending on how handover is performed; the use of medical jargon during handover can be an information barrier for patients.

This theme was subdivided as follows: intervention studies, non-intervention studies, reviews, and barriers to bedside handover.

1.1 Intervention studies

Polit & Beck (2014) describe intervention research as a process of planning, developing, testing and publishing study findings to indicate advantages and disadvantages in the application of a specific practice, in this case bedside handover. Ten studies (Appendix 5) investigated patients' perceptions throughout the process of handover being changed from office to bedside. Seven of these studies (Appendix 5) used a longitudinal design, where data was collected at multiple points over a period of time, thereby strengthening the results (Polit & Beck 2014).

Anderson & Mangino (2006) used the monthly quantitative patient satisfaction survey of a large American hospital (600 beds) to evaluate the implementation of bedside handover in a surgical ward (32 beds). The results showed an increase of 5% in patients feeling that they were being kept informed. This study indicated that bedside handover enhanced patient satisfaction. Identical results were found in a study by Cairns et al. (2013); also in an American hospital, a monthly quantitative patient satisfaction survey showed an increase in patient satisfaction due to nurses keeping them informed; from 73.8% in September of the relevant year, before bedside handover implementation, to 91.1% in December, after implementation. This pilot study took place in one unit (23 beds) in a short period of time (3 months); the responses obtained may not represent the overall population, and thus the results cannot be generalized (Polit & Beck 2014).
Sand-Jecklin & Sherman (2014) conducted a quasi-experimental study in a large American university hospital to assess patient satisfaction at three and 13 months after implementation of bedside handover. They also compared their findings with a survey conducted before implementation. Both studies used convenience samples. In comparison with the data from the pre-implementation study (n=233), the majority of respondents after implementation (3 months n=157 and 13 months n=154) felt more informed (satisfaction increased 8% in the first 3 months and 10% in 13 months) about plans of discharge and test/procedures.

Some inconsistencies about the use of bedside handover were reported in this study, but not measured in the data collection; this may have influenced the results for participating patients who had not experienced bedside handover. Maxson et al. (2012) conducted a quantitative survey with a convenience sample of patients before (n=30) and after (n=30) the implementation of bedside handover in an American hospital. This study showed that the patients’ perceptions of being informed about their plan of care increased. In both the Sand-Jecklin & Sherman (2014), and Maxson et al. (2012) studies, the sampling method used was weak; convenience samples using patients that are available may not be representative of the total population for those studies (Polit & Beck 2014).

In a quantitative study conducted in an American hospital, Wakefield et al. (2012) used results from a patient satisfaction survey conducted six months before implementation and six and 23 months after implementation of bedside handover. Patients’ participation ranged from eight to 20 each month. The results were compared longitudinally to satisfaction surveys from other hospitals with similar wards. For the first six months after implementation, the patients’ perceptions of nurses keeping them informed was high (94%), compared with the entire 23 months (87%), but patients’ satisfaction was still above the pre-implementation baseline (83%). This study used a small convenience sample, with a low response rate. Responses may also have been affected by the fact that patients were still hospitalized, meaning they may have answered more positively than they would after discharge. Ensuring confidentiality and lessening the risk of any awkwardness or embarrassment could reduce this potential bias (Polit & Beck 2014). In a similar study, Sand-Jecklin & Sherman (2013) used the results of a Patient Views on Nursing Care survey, pre-implementation (n=232) and post-implementation (n=178) of bedside handover, to compare patient satisfaction;
these showed small improvements after implementation in keeping patients informed.

Freitag & Carroll (2011) used a quantitative survey after implementation of bedside handover in a pilot unit and afterwards in the whole hospital. This study showed an increase in patients’ satisfaction when they were asked if nurses had kept them informed, compared to a baseline survey. A limitation of this study is that no sample size or sampling technique were mentioned, so it is not possible to judge if the researchers made good choices in sampling decisions and thus it is difficult to determine the relevance of the evidence to practice (Polit & Beck 2014).

Another study that does not specify the sample size is by Chaboyer et al. (2009), who conducted a qualitative survey after bedside handover was implemented in three units in an Australian hospital with 330 beds. This study found that patients think positively about the new handover process and that it is a way they can be kept informed (Chaboyer et al. 2009). In this study, the evaluation was performed informally by nurses, at the bedside, which could have influenced the results (Polit & Beck 2014).

In a mixed-method study, research nurses interviewed and surveyed a convenience sample of participants (n=107) who had experienced bedside handover (Friesen et al. 2013). This study showed that patients were positive about the new practice. Prior to implementation of bedside handover, the patients in this study perceived nurses as going to a “secret place” for handover, rather than being at the bedside where patients could listen to the information being passed on. Friesen et al. (2013) observed also that nurses explained to patients what they did not understand, thus increasing the patients’ feeling of being informed.

Similar findings were discovered made in Bradley & Mott’s (2013) study, where interviews with nine patients, who had volunteered to participate, were carried out in three rural Australian hospitals. The results show that patients believed it was important to know the plan of care, feeling that their opinion counted and being able to ask questions of the nurses to improve their knowledge. The study limitations were the sample size and time constraints, which led to superficial understanding of the patients’ perceptions (Bradley & Mott 2013).

1.2 Non-intervention studies
During interviews with patients (n=30) in an Australian hospital (medical, surgical and maternity wards), Lu et al. (2014) investigated perceptions about bedside handover. Patients expressed their need for information and a right to know about diagnoses and plans of care (Lu et al. 2014). “Listening to handover” was an opportunity to obtain the information they needed to feel more confident and in control (Lu et al. 2014). This study used a purposive sample. Researchers applied their own knowledge of patients to select participants, or believed that particular patients had enough knowledge to give an insight into bedside handover, ensuring patient experience and exposure to this type of handover for the purposes of gathering in-depth information (Ryan et al. 2007, Polit & Beck 2014). Greaves (1999), when working in a hospital in England, interviewed four patients prior to discharge, and found they had a great need for information and wanted to ask and be asked questions, not to actually make decisions but to be kept informed. The findings cannot be generalized due to the convenience sample and sample size (Polit & Beck 2014).

McMurray et al. (2011), who conducted a descriptive case study (n=10), found that the patients’ preferences for bedside handover included being informed, understanding the expectations for their progress and their plan of care, and ensuring the correctness of information. This study showed that patients preferred to listen to the handover rather than participate, and be given the opportunity to ask questions at the end. Jeffs et al. (2014) had similar results to McMurray et al. (2011), but the method of collecting data was qualitative. A total of 45 patients from six different clinical cohorts were interviewed. Patients described their views on bedside handover and interviews were conducted until saturation of data collection was achieved, when no new information was identified (Polit & Beck 2014).

1.3 Literature reviews

Vines et al. (2014) conducted a review of the literature about the level of patients’ satisfaction during bedside handover. In total nine studies were used for this review, which found that this type of handover increased patients’ perceptions of being informed and increased satisfaction, facilitating patient centred-care. In a systematic review to investigate the advantages and disadvantages of bedside handover, Sherman et al. (2013) found similar patient views. They reviewed 12
articles, of which 10 showed evidence of patients feeling more informed, thus improving satisfaction with their care and their relationship with nurses.

1.4 Barriers to being informed

Four studies mention the use of medical jargon as a barrier to patients’ understanding of handover information, which increases their anxiety (Cahill 1998, Kerr et al. 2013, Sherman et al. 2013, Lu et al. 2014). Lu et al. (2014) showed that patients had some concerns about how much both they and new nurses could understand during handover because of the technical language used. Sherman et al. (2013) highlighted disadvantages to bedside handover such as medical jargon, patients tired of repeatedly hearing handover information, and anxiety due to receiving incorrect information about care.

Cahill (1998), in an early qualitative study in which patients were interviewed (n=10), found that the language used at bedside handover could be perceived negatively by patients, as controlling and manipulative, or positively, where the use of medical jargon could indicate the extent of the nurses’ knowledge. Kerr et al. (2013) observed that patients might not be English-speakers and thus would not understand what was said in handover at all.

Overall, the literature appears to agree that bedside handover keeps patients informed about their plan of care, diagnoses and treatment. Anderson & Mangino (2006) emphasised that promoting reassurance among patients can speed recovery. Some barriers in communication that can increase anxiety were pointed to by patients; nurses need to improve their communication skills and reduce the use of medical jargon to facilitate patients’ understanding. A key limitation of the research reviewed under this theme was that most of the studies used convenience sampling. Surveying patients who are easily available may mean that they represent an atypical population, giving rise to a high risk of bias which can influence the final findings (Polit & Beck 2014).
2. Being Involved

Patients’ perceptions about being involved in their care was discussed in 11 studies that examined the patients’ interest in being part of the handover. Most of the study findings under this theme show that patients want to be part of their care, and that being involved in handover improves patient satisfaction.

In an Irish 142-bed hospital, bedside handover was implemented in one 12-bed unit. A short questionnaire was distributed to patients (n=10). The results revealed that eight patients felt more involved in their care (Kelly 2005). The author of this study suggests that the sample was chosen randomly, and the sample was small. A better description of the sampling method is necessary to ensure that the conclusions of this study are strong enough to be used in practice (Polit & Beck 2014). Kassean & Jagoo (2005) conducted a mixed-method study, with interviews and observations, after the implementation of bedside handover in a gynaecological ward in a hospital in Mauritius. Semi-structured interviews were conducted with randomly chosen patients (n=40). The majority of patients felt involved in their care (80%) and all patients felt positively about nurses discussing their care at their bedside (Kassean & Jagoo 2005). Kassean & Jagoo’s (2005) observational data was collected by non-participants, which gave the researchers a better understanding of the experiences and behaviours of patients at bedside handover (Polit & Beck 2014). Kerr et al. (2013) found that patients’ involvement in handover improved understanding of their condition and contributed to important or neglected information; for example, their own medication, treatment feedback and chronic conditions (diabetes, COPD), but they also found that nurses should be discreet about new (e.g. patient not aware of diagnoses) or sensitive information (Kerr et al. 2013).

Ford et al. (2014) used closed-ended questions in their survey of 103 patients, in surgical and medical wards, after implementation of bedside handover. This study showed that, if bedside handover was experienced regularly, patients’ perception of involvement in their care was increased (Ford et al. 2014). The researchers used closed-ended questions, which are often used because they are easy to analyse and easy for patients to answer, but they may reveal only superficial data (Polit & Beck 2014).
Similar results were found in many studies, where patients wanted to be part of their care and bedside handover gave them this opportunity (Greaves 1999, Anderson & Mangino 2006, McMurray et al. 2011, Bradley & Mott 2013, Cairns et al. 2013, Sand-Jecklin & Sherman 2013, Jeffs et al. 2014, Sand-Jecklin & Sherman 2014, Vines et al. 2014). For example, Cairns et al. (2013) found an increase in patient satisfaction about nurses’ involving them in their care, from 69.7% in September, before bedside handover, to 83.9% in December after implementation. Maxson et al. (2012) highlighted patients’ impression of being partners and actively participating in the multidisciplinary team during bedside handover.

A number of studies have identified patients’ preferences for different roles during bedside handover. Greaves (1999) suggests that patients prefer to be passively involved in handover, while McMurray et al. (2011) concluded that different patients want different levels of interaction. Involving patients in bedside handover promotes shared decision-making and is an important element in patient-centred care (Greaves 1999, McMurray et al. 2011).
3. Continuity of Care

This theme will analyse patients’ perceptions about the information that is shared between nurses during bedside handover and the extent to which nurses work as a team. Patient information should be up-to-date, relevant and correct, and include changes that have occurred in the last 24 hours (DoH 2014).

Greaves (1999) found that, when patients can observe nurses sharing information during bedside handover, the treatment is made more personal because patients and nurses get to know each other (Greaves 1999). Other studies highlighted the importance for patients of knowing the nurse who is taking over their care, making them feel more reassured, and increasing trust and improving the patient-nurse relationship (Bradley & Mott 2013, Friesen et al. 2013, Sand-Jecklin & Sherman 2013, Sherman et al. 2013).

Two studies (Kassean & Jagoo 2005, Freitag & Carroll 2011), using patient satisfaction surveys, found that patients were more pleased when nurses worked together and shared information during handover. Anderson & Mangino’s study (2006) reinforces these results, suggesting that patients recognize how well nurses work together when everyone knows about the patient’s plan of care.

Sand-Jecklin & Sherman, in two separate studies (2013 and 2014), suggested that patients know, through bedside handover, when important information is being passed on between nurses. In a qualitative descriptive study (n=30) exploring patients’ perspectives of bedside handover in an emergency department in Australia, Kerr et al. 2013 suggest that bedside handover made patients feel less anxious because they knew that the nurses had enough knowledge (condition, plan), and transition of care was provided between shifts. When patients can listen during handover, they are more confident about the care they are receiving (Kerr et al. 2013). This finding was confirmed by Lu et al. (2014), where patients suggested that this practice helps nurses to obtain better knowledge of patients’ conditions, needs and tasks to be completed.

The information shared between nurses during bedside handover may be more than clinical information. For example, in Bradley & Mott’s (2013) study, a patient wished to go to the mosque and this request was passed on to the next shift, showing that the nurses wanted to meet the patient’s personal as well as clinical needs. Bradley & Mott (2013) and Ford et al. (2014) suggest that bedside
handover gives patients opportunities to see nurses planning ahead to meet their needs, which gives the patients a sense of safety and empowerment.

In an American hospital, Radtke (2013) conducted a pilot bedside handover study to improve communication between patients and nurses. A discharge patient survey (n=280) showed the need for enhancement of communication, and management decided to implement bedside handover in a medical/surgical ward to evaluate if it would help improve patient satisfaction. After three months of implementation, 44 patients were interviewed and 20 were surveyed. The study showed an increase in patients’ perceptions of continuity of care and of nurses meeting their individual care needs. This study was strengthened by the adoption of Lewis’s Planned Change Theory to guide the process of change (Polit & Beck 2014).

Patients’ confidence in the competence and knowledge of nurses was strengthened by bedside handover (Cahill 1998, Bradley & Mott 2013, Kerr et al. 2013). However, some patients felt that the information provided was not as complete as it should be, pointing to some omissions concerning post-operative care and conflicting information delivered during handover, causing confusion. For this practice to work, from the patient’s point of view, nurses need to exchange comprehensive, precise and clear information to ensure continuity of care (Cahill 1998).
4. Confidentiality

In the literature reviewed here, the nurses’ main concern about bedside handover is confidentiality (DoH 2014); however, most patients agree that the positive aspects of bedside handover outweighed concerns about confidentiality.

Howell (1994) interviewed patients (n=20) in a United Kingdom hospital to determine their perceptions of confidentiality during bedside handover. The findings suggested that patients (n=18) did not see confidentiality as an issue of concern in this type of handover (Howell 1994). Howell (1994) highlighted that 75% of the patients interviewed believed that others were not listening to their information being passed on during bedside handover, while 80% of patients said they did not listen to other patients' information at all. These findings are consistent with Greaves’s (1999) study, where patients suggested that ‘not listening’ to other patients’ information is a coping skill to avoid awkward situations.

Some studies (McMurray et al. 2011, Bradley & Mott 2013, Sand-Jecklin & Sherman 2013, Sherman et al. 2013, Lu et al. 2014, Sand-Jecklin & Sherman 2014) concluded that a minority of patients had some concerns about confidentiality during bedside handover, where family members are present, and about certain types of information shared (sexually transmitted diseases, religion, mental conditions) or where rooms were shared by male and female patients. On the other hand, the majority of patients thought that being informed outweighed concerns about privacy.

For bedside handover to succeed, it is important that nurses avoid speaking loudly and manage sensitive information carefully, ensuring that their report does not lead to discrimination against patients because of the type of information shared (Bradley & Mott 2013, Kerr et al. 2013, Lu et al. 2014). Most patients are not overly concerned about confidentiality at bedside handover, but the ward environment (distance between patients’ beds) needs to be considered to improve patients’ satisfaction (Howell 1994, Cahill 1998, McMurray 2011, Lu et al. 2014).
Conclusion

The purpose of this literature review was to explore patients’ perceptions about nursing bedside handover. Before implementing bedside handover, it is important to understand how patients experience being part of the process. Identifying both the positive aspects and the barriers to bedside handover can help to improve practice.

In summary, the literature showed a consensus among patients on being informed about their care, but the way that the information is shared needs to be handled sensitively by nurses. The type of information and the setting need to be considered during handover to enhance patient satisfaction. Confidentiality issues were outweighed by the advantages that bedside handover brings to patients, who perceive that relevant information is being passed on to the next shift, ensuring continuity of care.

This literature review may have limitations due to the fact that this is the first study of this kind to be carried out by the author. Other limitations are that seven of the studies examined used convenience sampling, the weakest method in research, with a high risk of bias; five of the studies did not even describe the sample size used, which means that it is difficult to conclude if the evidence can be used in practice; and of the 13 intervention studies, only two used a randomly chosen sample. Generalizing the findings is questionable if the sampling methods are incomplete or not strong enough to support the evidence (Polit & Beck 2014).

Recommendations for further research

In light of the methodological limitations noted above, further research on bedside handover should include larger sample sizes and more randomised studies, so that the population is well represented and the findings can be generalized (Polit & Beck 2014). Furthermore, all studies used in this literature review were conducted in acute hospitals; research in different health settings is needed, showing that the data collected has credibility, confirmability and transferability (Polit & Beck 2014).

Recommendations for practice

The findings of this review suggest that bedside handover improves patient satisfaction and outcomes. A fusion between handover at bedside and a small handover in the nurse station would facilitate the exchange of sensitive
information, better ensuring confidentiality. The use of a change of practice model involving patients and nurses would facilitate the development of communication skills and better nurse practice.
References


Health Information and Quality Authority (2013) *Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital Galway, and as reflected in the care and treatment provided to Savita Halappanavar*. Stationery Office, Dublin.


# Appendix 1: Tabulation of Online Database Search

<table>
<thead>
<tr>
<th>Database</th>
<th>Language</th>
<th>Search date</th>
<th>Search Terms</th>
<th>Number of Hits</th>
<th>Number Discarded (Unrelated articles)</th>
<th>Number Discarded (Title and abstract)</th>
<th>Number Reviewed (Full Text)</th>
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<td>English</td>
<td>11/01/2015</td>
<td>handover or handovers OR hand-over OR hand-overs OR handoff or handoffs OR &quot;shift report&quot; OR &quot;shift reports&quot; OR &quot;change of shift&quot; OR &quot;change of shifts&quot; AND bedside OR bedsides</td>
<td>41</td>
<td>8</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Peer Reviewed</td>
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<tr>
<td>Full text</td>
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<tr>
<td>The Cochrane Library</td>
<td>English</td>
<td>11/01/2015</td>
<td>handover or handovers OR hand-over OR hand-overs OR handoff or handoffs OR &quot;shift report&quot; OR &quot;shift reports&quot; OR &quot;change of shift&quot; OR &quot;change of shifts&quot; AND bedside OR bedsides</td>
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</tbody>
</table>
Appendix 2: Flowchart of Online Searches

Search on the 11-01-2015

45 articles found from AMED, CINAHL, and MEDLINE in English language, peer reviewed

Discarded unrelated title 12

Reviewed title and abstract 33

Number discarded (title and abstract) 15

Number reviewed (full text) 18

41 articles found from PUBMED in English language, peer reviewed

Discarded Unrelated Title 8

Reviewed title and abstract 34

Number Discarded (Title and abstract) 16

Number Reviewed (Full Text) 17
## Appendix 3: Summary Table for Research Studies Included in Review

<table>
<thead>
<tr>
<th>Author(s) and Title</th>
<th>Study Aims &amp; Objectives</th>
<th>Research Design</th>
<th>Sample</th>
<th>Data Collection Methods</th>
<th>Data Analysis Method</th>
<th>Findings relevant to the review.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradley S. &amp; Mott S. (2013) Adopting a patient-centred approach: an investigation into the introduction of bedside handover to three rural hospitals. Australia</td>
<td>To study the process and outcomes of bedside handover implementation in three rural hospitals</td>
<td>Intervention study</td>
<td>9 patients Convenience sample</td>
<td>Quantitative method Interviews with 3 patients in each hospital</td>
<td>Spradley’s Taxonomic Analysis process, identifying domains and terms, and their correlation</td>
<td>- Being informed - Being involved - Continuity of care - Confidentiality</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Study Title</td>
<td>Country</td>
<td>Study Objective</td>
<td>Study Design</td>
<td>Sample Size</td>
<td>Data Collection</td>
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<tr>
<td>Cahill J. (1998)</td>
<td>Patient's perceptions of bedside handovers</td>
<td>United Kingdom</td>
<td>To describe and analyse the patients' perceptions of bedside handover</td>
<td>Descriptive qualitative study</td>
<td>10 patients</td>
<td>Theoretical sample</td>
</tr>
<tr>
<td>Chaboyer W., McMurray A., Johnson J., Hardy L., Wallis M. &amp; Chu F.Y. (2009)</td>
<td>Bedside Handover: Quality improvement strategy to “transform care at the bedside”</td>
<td>Australia</td>
<td>To describe the quality improvement project of implementation of bedside handover</td>
<td>Intervention study</td>
<td>Not mentioned</td>
<td>Qualitative method</td>
</tr>
</tbody>
</table>

Themes:
- Being informed
- Continuity of care
- Confidentiality
<table>
<thead>
<tr>
<th>Authors</th>
<th>Study Title</th>
<th>Methodology</th>
<th>Sample Size</th>
<th>Inclusion Criteria</th>
<th>Quantitative Method</th>
<th>Descriptive statistics used to summarize sample and person correlations to determine significance responses to individual items</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ford Y., Heyman A. &amp; Chapman Y.L. (2014)</td>
<td>Patients' perceptions of bedside handoff: the need for a culture of always.</td>
<td>Descriptive study</td>
<td>103 patients, inclusion criteria age over 18, fluency in spoken and written English and no diagnoses of dementia or confusion Convenience sample</td>
<td>Quantitative method Survey with demographic information, if experienced bedside handover, and perceptions The instrument was peer reviewed (reliability 0.92)</td>
<td>Descriptive statistics used to summarize sample and person correlations to determine significance responses to individual items IBM Statistical Package for the Social Sciences, version 20 for Windows was used to analyse responses.</td>
<td>- Being involved</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title &amp; Country</td>
<td>Objective</td>
<td>Method &amp; Design</td>
<td>Sample &amp; Data Collection</td>
<td>Data Analysis</td>
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<tr>
<td>Friesen M.A., Herbst A., Turner J.W., Speroni K.G. &amp; Robinson J. (2013)</td>
<td>Developing a patient-centered ISHAPED handoff with patient/family and parent advisory councils USA</td>
<td>To explore patients’ perceptions of ISHAPED bedside handover</td>
<td>Intervention study Mixed method – Explanatory designs First quantitative data collection than qualitative data</td>
<td>107 patients, English speakers, were surveyed 22 were interviewed after Convenience sample</td>
<td>8 nurses/researchers surveyed and interviewed patients Demographic information and 11 survey questions completed by patients Semi-structured interview using interview guide question; answers recorded, transcribed verbatim and downloaded to Nvivo 9 software</td>
<td>Survey of the item, means and frequencies were used to analyse responses Interview was a line-by-line technique and grounded theory – constant comparative method - and grouped in themes (thematic content analysis)</td>
<td></td>
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<tr>
<td>Greaves C. (1999)</td>
<td>Patients’ perceptions of bedside handover United Kingdom</td>
<td>To explore patients’ perceptions of bedside handover Descriptive qualitative study</td>
<td>4 patients, excluded: patient with English as second language, withdraw, awaiting transfer or had dysphagia Theoretical sample</td>
<td>Patient recruited on admission and interviewed prior to discharge using semi-structured interviews Tape-recorded and transcribed verbatim</td>
<td>List of statements was made; categorised by theme (thematic content analysis) Data were also coded by a colleague to reduce researcher bias</td>
<td>- Being informed - Continuity of care - Being involved - Confidentiality</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Study Title</td>
<td>Study Objective</td>
<td>Methodology</td>
<td>Sample Characteristics</td>
<td>Data Collection</td>
<td>Data Analysis</td>
<td>Reporting</td>
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<tr>
<td>Howell M. (1994)</td>
<td>Confidentiality during staff reports at the bedside.</td>
<td>To examine perceptions about confidentiality during bedside handover</td>
<td>Intervention study</td>
<td>20 patients randomly selected, criteria being in the ward for more than three days and able to understand and answer the interview questions</td>
<td>Self-report method, interview schedule, with 6 closed-ended questions and 2 open-ended, face-to-face interview</td>
<td>Descriptive statistics and outlined comments</td>
<td>- Confidentiality</td>
</tr>
<tr>
<td>Jeffs L., Beswick S., Acott A., Simpson E., Cardoso R., Campbell H. &amp; Irwin T. (2014)</td>
<td>Patients’ views on bedside nursing handover: creating a space to connect.</td>
<td>To explore patients’ perceptions and experience with implementation of bedside handover</td>
<td>Descriptive qualitative study</td>
<td>45 patients, inclusion criteria 18 or over, understand English, able to consent and experience bedside handover</td>
<td>Interview self-report, face-to-face until saturation data achieved with 4 guide questions</td>
<td>Directed content analysis, divided in 3 key themes</td>
<td>- Being informed - Being involved</td>
</tr>
<tr>
<td>Study</td>
<td>Purpose</td>
<td>Methodology</td>
<td>Findings</td>
<td>Themes</td>
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<tr>
<td>[Kassean H. K &amp; Jagoo Z.B. (2005)] Managing change in the nursing handover from traditional to bedside handover - a case study from Mauritius.</td>
<td>To address the implementation of bedside handover and some disadvantages of ‘old-style’ handover</td>
<td>Descriptive case study</td>
<td>Observation of 10 bedside handovers with a protocol, of 6-point criteria Semi-structured interviews using a questionnaire developed from a focus group Observations and interviews were analysed with descriptive statistics and comments outlined</td>
<td>- Being involved</td>
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</tr>
<tr>
<td>[Kelly M. (2005)] Change from an office-based to a walk-around handover system.</td>
<td>To determine the views of the present handover, to introduce change to bedside handover, include staff in change process, patient and staff perceptions of bedside handover</td>
<td>Intervention study</td>
<td>Short questionnaire given randomly in the ward area Not mentioned Data presented in charts and statistics summary</td>
<td>- Being involved</td>
<td></td>
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</tr>
<tr>
<td>[Kerr D., McKay K., Klim Sharon, Kelly A. &amp; McCann T. (2013)] Attitudes of emergency department patients about handover at the bedside.</td>
<td>To study the patients’ perceptions of bedside handover in emergency department</td>
<td>Descriptive qualitative study</td>
<td>Semi-structured interview with interview schedule, face-to-face audio recorded and transcribed Thematic content analysis Themes were decided using criteria of general for all cases, typical for at least half cases, variant greater than two cases, data referred in one or two were not included.</td>
<td>- Being informed - Being involved - Continuity of care - Confidentiality</td>
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</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Country</td>
<td>Study Goal</td>
<td>Study Design</td>
<td>Sample Size</td>
<td>Inclusion Criteria</td>
<td>Data Collection Method</td>
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</tbody>
</table>
| 2014     | Lu S., Kerr D. & McKinlay L.      | Australia | To study patients perceptions of bedside handover | Descriptive qualitative study with phenomenological approach | 30 patients, inclusion criteria English speakers, age more than 18, in the ward more than one night and observed as least two handover | Interviews face-to-face, semi-structured, audio recorded and transcribed. Used an interview schedule and prompts to encourage responses. | Thematic content analysis | - Being informed  
- Continuity of care  
- Confidentiality |
| 2012     | Maxson P.M., Derby K.M., Wroblewski D.M. & Foss D.M. | USA | To determine if bedside handover increases patient satisfaction about their care plan and perceptions of teamwork | Intervention study | 60 patients, inclusion criteria 18 or older, understanding of English and no cognitive impairment  
30 patients before and 30 after implementation | Investigator-developed survey Pre and post implementation | Descriptive statistics and outlined comments Used chi-squared analysis and Wilcoxon rank-sum test | - Being informed  
- Being involved |
<table>
<thead>
<tr>
<th>Authors</th>
<th>Title</th>
<th>Country</th>
<th>Objective</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Data Collection</th>
<th>Data Analysis</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>McMurray A., Chaboyer W., Wallis M., Johnson J. &amp; Gehrke T. (2011)</td>
<td>Patients' perspectives of bedside nursing handover.</td>
<td>Australia</td>
<td>To study patient perceptions of bedside handover</td>
<td>Descriptive case study</td>
<td>10 patients, inclusion criteria: English speakers and in the ward for at least one night; exclusion: critically ill, infectious or unable to consent</td>
<td>Interviews were audiotaped, transcribed, semi-structured face-to-face interviews, using an interview schedule</td>
<td>Thematic content analysis Refined and emerged and organized codes into themes, analysing data for consistency.</td>
<td>- Being informed - Being involved - Confidentiality</td>
</tr>
<tr>
<td>Radtke K. (2013)</td>
<td>Improving patient satisfaction with nursing communication using bedside shift report.</td>
<td>USA</td>
<td>To determine if standardized bedside handover improve patient satisfaction</td>
<td>Intervention study</td>
<td>Not specified for patient satisfaction survey During the study 44 patients interviewed and 20 surveyed</td>
<td>Patient satisfaction data was monitored by external data collection (professional research consultant) During study not mentioned Pre and post implementation</td>
<td>Descriptive statistics and outlined comments</td>
<td>- Continuity of care</td>
</tr>
<tr>
<td>Sand-Jecklin K. &amp; Sherman J. (2013)</td>
<td>Incorporating bedside report into nursing handoff: evaluation of change in practice.</td>
<td>USA</td>
<td>To evaluate patient satisfaction with bedside handover</td>
<td>Intervention study</td>
<td>232 patients pre implementation 178 patients post implementation Convenience sample</td>
<td>Adaptation of patients' views on nursing care (17 questions with 5-point response option), peer reviewed; reliability of 0.96 and inter-item correlation 0.49 to 0.80 (indicating similar but not identical) With comment optional on the post implementation survey</td>
<td>Independent t-test comparisons Descriptive statistics analysed comments</td>
<td>- Being informed - Being involved - Continuity of care - Confidentiality</td>
</tr>
<tr>
<td>Study</td>
<td>Objective</td>
<td>Study Design</td>
<td>Sample Size</td>
<td>Measures</td>
<td>Analysis</td>
<td>Findings</td>
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<tr>
<td>Sand-Jecklin K. &amp; Sherman J. (2014) A quantitative assessment of patient and nurse outcomes of bedside nursing report implementation. USA</td>
<td>To measure the outcomes of implementation with bedside handover</td>
<td>Intervention study</td>
<td>233 patients baseline data 157 patients 3 months after implementation 154 patients 13 months after implementation Convenience sample</td>
<td>Adaptation of patients' views on nursing care (17 questions with 5-point response option), peer reviewed; reliability of 0.96 and inter-item correlation 0.49 to 0.80 (indicating similar but not identical)</td>
<td>ANOVA comparisons and Dunnett T-3 post hoc comparisons</td>
<td>Being informed, Being involved, Continuity of care, Confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wakefield D.S., Ragan R., Brandt J. &amp; Tregnago M. (2012) Making the transition to nursing bedside shift reports. USA</td>
<td>To improve patients' satisfaction by introducing bedside handover</td>
<td>Intervention study</td>
<td>Patients' participation ranged from 8 to 20 each month</td>
<td>Questionnaire with structured interviews Pre and post implementation</td>
<td>Longitudinal tracking on the mean scores and comparison to data in other hospitals Data presented in descriptions and charts</td>
<td>Being informed</td>
<td></td>
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</tr>
</tbody>
</table>
### Appendix 4: Summary Table for Literature Reviews and Systematic Reviews

<table>
<thead>
<tr>
<th>Author(s) &amp; Title</th>
<th>Research Question/ Purpose</th>
<th>Search Strategy/ Inclusion/ Exclusion Criteria</th>
<th>Search Terms</th>
<th>Details of Literature/ Study Selection</th>
<th>Quality Assessment (where applicable)</th>
<th>Data Synthesis (where applicable)</th>
<th>Findings/ Conclusions relevant to the review</th>
</tr>
</thead>
</table>
Appendix 5: Intervention studies

**Intervention studies**


**Longitudinal studies**