

Nursing handovers: do we *really* need them?

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Aim This study attempts to address the content of nursing handover when compared with formal documentation sources.

Background The nursing handover has attracted criticism in the literature in relation to its continuing role in modern nursing. Criticisms include those related to time expenditure, content, accuracy and the derogatory terms in which patients are sometimes being discussed.

Methods Twenty-three handovers, covering all shifts, from one general medical ward were audio-taped. Their content was analysed and classified according to where, within a ward's documentation systems, the information conveyed could be located.

Findings Results showed that almost 84.6% of information discussed could be located within existing ward documentation structures and 9.5% of information discussed was not relevant to ongoing patient care. Only 5.9% of handover content involved discussions related to ongoing care or ward management issues that could not be recorded in an existing documentation source.

Limitations The results of this study are representative of only one ward in one Australian Hospital. Specific documentation sources were also not checked to determine their content.

Conclusion Streamlining the nursing handover may improve the quality of the information presented and reduce the amount of time spent in handover.

Keywords: communication, documentation, handover, nursing care plan, patient medical record

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Introduction

Continuity of patient care in the acute hospital depends on the existence of efficient and effective mechanisms of communication between all health care team members. Whilst the written format that makes up the patient

health record, such as progress notes, medication charts, observation charts and nursing care plans, forms the basis of communication between health disciplines, the nursing handover continues to occupy a salient role in nurse to nurse communication. These handovers however often lack formal structure and this is com-

pounded by a lack of guidelines for the nurse giving the report. Consequently, the information presented may be irrelevant, repetitive, speculative or contained in other information sources. As such, the time spent in handover may be wasted if the incoming nurses are not being given useful information. The aim of this paper is to discuss a project undertaken to empirically study the nursing handover content in a busy acute care ward of a metropolitan hospital. The paper builds upon the authors' views of the existing literature on nursing handovers, which tends to be rather anecdotal in nature.

Literature review

Despite research exploring the role of handover in patient care delivery over the past 15 years (e.g. Mathews 1986, Liukkonen 1993, McKenna 1997), recommendations for adjustment to the structure and/or delivery process (e.g. Smith 1986, Miller 1998) to improve accuracy and relevance of the information have failed to be adopted on a broad scale. Various authors, such as McKenna (1997), Miller (1998) and Williams (1998) have commented that the handover process is often time consuming. Baldwin and McGinnis (1994) anecdotally reported that lengthy verbal reports result in excessive overtime and an inability to meet patients' needs during the report. This situation may obviously vary from ward to ward and is influenced by many factors, such as the style of handover used, the number of patients on the ward and staffing levels.

Four main styles of handover are reported in the literature: the verbal handover, which takes place in a designated location; tape recorded; handover at the bedside; and written handover in which the 'incoming' nurses access existing documentation to ascertain essential information. McKenna's (1997) review of the literature however could not identify one single handover method as being superior and suggested that producing written guidelines for handover may encourage consistency and thus increase the quality of the report given.

So, what is being stated during handover? Mosher and Bontomasi (1996) taped an undisclosed number of handovers in their hospital and found that they took an average of 45–50 minutes to complete. The information conveyed during these handovers included the frequency of vital signs and the patient's diet and activity status. Kennedy (1999) found that information traditionally described in the nurses' handover included the patient's name, age, diagnosis and an outline of the shift's events. Other studies (Prouse 1995, Sherlock 1995, Strange 1996) have identified handover content

similar to that reported by Kennedy (1999), although additional information is often included.

In a report on their observational study of 12 nursing handovers on eight different wards, Parker *et al.* (1992) suggested that 'doctors and other health professionals record their observations in the knowledge that their assessments will be read and acknowledged by their colleagues'. They state that if nurses adopted this approach and attitude, less time could possibly be spent performing the nursing handover allowing more time for patient care. Handover may be time consuming for numerous reasons and there is a distinct lack of consistency and formal guidelines for handover in the literature. Baldwin and McGinnis (1994) minimized the problems by changing from an unstructured, verbal report to a structured format with staff guidelines for giving and receiving report.

Mosher and Bontomasi (1996) found that more essential information, such as how well the patient tolerated their diet or how far they ambulated, was omitted from nursing handovers. But even this type of information could be documented in the nursing notes, thus reducing the time spent in handover. Kennedy (1999) reported that nursing care plans were referred to in handover only 1% of the time and this was probably because care plans were not being updated. This situation creates a vicious cycle. If the care plans were updated, the incoming nurses could read them and identify the patients' problems and the nursing strategies to manage them, thus eliminating this information from the handover. However, as information centered on what was done and not what they plan to do and care plans are not updated, information on care plans needs to be reported in handover (Kennedy 1999).

Sherlock (1995) performed a participant observation study to explore the quality and effectiveness of the handover process. Whilst the content included the biographical data mentioned above, many of the patient problems described were not amenable to nursing intervention, non-specific descriptions were used and some phrases were open to interpretation. Williams (1998) similarly reported, though anecdotally, that whilst a typical report included the medical diagnosis and a list of events from the shift, the content often deteriorated into 'irrelevant and outdated statements, unrelated to the patient's progress'. Jordan (1991) studied handover in two psychiatric wards and found that 72.5% of information related to the activities on the previous shift and was of basic nature (e.g. 'patient went to occupational therapy'). She concluded that much of the information could be located in the existing written records.

The literature highlights the need for a more comprehensive understanding of the content of handover with the view to identifying the information already transmitted in existing recording structures. With the exception of work undertaken by Parker (Parker *et al.* 1992, Parker & Wiltshire 1995, Parker 1996, Wiltshire & Parker 1996), the majority of published reports tend to be anecdotal, isolated projects driven at a ward level (e.g. Reiley & Stengrevics 1989, Wallum 1995, McKenna 1997, Kennedy 1999), perhaps questioning the scientific validity of the conclusions. Such reports do, however, provide an indication of the universality of explicit and implicit functions of handover and the inherent problems in the process and of various handover styles.

Aim

Having contemplated the limitations of the literature to date, the existing study was designed with the aim of examining the content of verbal nursing handover in relation to existing documentation structures in a general medical ward. While numerous studies provide anecdotal evidence of handover content, few have examined it through a process of systematic content analysis and none have attempted to address the issue of redundancy of reporting. For example, how much information exchanged during handover is already noted in documentation sources? If a significant amount of the information exchanged is already available within a documentation system, the true value of handover could be re-examined in the light of this information and other means explored to fulfil the other less obvious, but just as important functions of handover. If a significant proportion of information turns out to be discursive in nature, such as didactic exchanges focussed on patient problems and the resolution of these, the importance of handover to overall care delivery will be underscored.

Method

The study was conducted in a 30 bed general medical ward in a 200 bed acute care facility, located in the western suburbs of Sydney. Twenty-three nursing handovers covering all the shifts were observed and audio-taped by two researchers. Participation was voluntary and written consent was obtained from all nurses involved. Confidentiality and impartiality were assured. Handover recordings were transcribed verbatim. Patient details and references to individual staff members were not transcribed. Analysis of data was performed using the QSR NuDist Vivo (1999) qualitative data analysis programme.

Categories or themes were created according to the specific handover content and data were then assigned to the appropriate category. Categories were established to reflect existing documentation structures of the study ward. For example, statements or questions relating to medication administration were classified under 'Medication Chart' and statements relating to nursing care requirements classified under 'Nursing Care Plan'. At no time were statements coded or categorized more than once. Information about ward documentation was coded to the physical location deemed to be the simplest, in reality, for the nurses to access. A separate 'non-charting' category was established for statements in which an appropriate location did not exist and/or the statement was inappropriate for documentation. This category was further divided into information relevant to ongoing patient care (e.g. care planning discussions) and information not relevant to patient care (e.g. debriefing, patient stereotyping). The NVivo programme was used to assign passages from the transcripts to the nodes that were created based on the categories identified earlier.

Following development of the coding structure and completion of preliminary coding, the data were presented, with examples, to a group of five senior nurse practitioners. They agreed the coding structure reflected ward documentation structures and current trends in hospital documentation. To reflect communication practises of the study ward an additional category, 'Charting/Noticeboard' was created for information appropriate to be placed on a nurses' station notice board. Whilst patient related, this category was for information not requiring formal documentation, but which is required to facilitate smooth ward management (such as appointment times and transport arrangements).

Results

Handover coincided with the commencement of the incoming shift. It was principally given by the Registered Nurse in charge of the patient to all the nurses coming on duty. Delays of up to 7 minutes were noted during the actual handover. Table 1 provides a breakdown of the handovers observed by time of day and the mean and range of handover length.

With the exception of one instance, no formal sources of patient information, such as care plans were seen to be used. Incoming nurses used a bed list, with patient name and diagnosis, to make notes during the handover. These lists, with additional information noted during the shift, served as the principal source of information for handover at shift completion.

Table 1
Breakdown of handovers observed, average length and range

Handover time (hours)	Number observed	Mean length (minutes)	Range (minutes)
07:00	7	18	15–22
14:30	9	39	30–50
22:45	7	33	27–40

Table 2
Number of coding occurrences across all categories

Category	Character count		No. of passages	
	Number	%	Number	%
Charting	244 522	69.5	3820	84.6
Non-charting				
Relevant	46 270	13.1	194	4.3
Irrelevant	53 307	15.2	431	9.5
Bed management	3546	1	47	1
Ward management	4171	1.2	24	0.5
Total	351 816	100	4516	100

Analysis consisted of specific counts from each category, which were conducted in two ways. First, character counts that reflected the total number of characters (letters and numbers) coded were conducted as a measure of the amount or quantity of speech coded in each category (see Table 2). In terms of the amount of information (the number of characters), 69.5% of the information discussed at handover could be incorporated into existing documentation, such as progress notes, observation charts or nursing care plans. While this suggests that 30% of information could not be incorporated into the documentation system, half of this information (15.2% of all nursing handover information) was deemed irrelevant to ongoing patient or ward management.

The second method used to quantify information was by counting the number of passages coded under each category (see Table 2). Each coded passage conveyed one thought, idea or topic of discussion. In terms of passage counts, 84.6% of information presented at handover could have been communicated via existing written documentation structures, such as those described earlier. Only 5.8% of all passages contained information important to ongoing patient care or bed or ward management that could not be documented in the existing documentation system. This figure was determined by adding the relevant 'non-charting' category to the 'bed management' and 'ward management' categories.

When passages (ideas/topics of discussion) are counted, the percentage in the charting category increased to 84.6%. This conveys that these passages in the non-charting category were longer (more characters) and

had a lower count than characters. Information coded in the 'charting' category tended to be abrupt statements relating to treatment regimes, care delivery or patient status, for example: 'oxygen via nasal prongs continues'. Information coded in the 'non-charting' categories tended to be in context of a discussion, reflecting the interactive nature of handover. For example:

Nurse One: 'and her BSL was 2.4 at one o'clock this afternoon so lemonade and biscuit was given and after one hour it was 4.5 but the doctor ordered the insulin stat dose ... it was four units it was given via subcut.'

Nurse Two: 'You will kill the patient.'

Nurse Three: 'four units.'

Nurse Two: 'Because it is too low the sugar and you gave insulin.'

Nurse Four: 'Was it 14 did you say?'

Nurse Three: 'She is 4.5 now she has got [an] IV canula insitu and because her BSL was low the doctor ceased the IV drug infusion.'

Nurse Four: 'So she didn't have the stat insulin.'

Nurse Three: No ... [talking over one another] ... she has daily UAs and daily weight and 1200 fluid restriction.'

Nurse Two: 'What did the UA show?'

Nurse Three: 'She is on nebuliser QID.'

Nurse Five: 'I am sorry how much fluid restriction.'

Nurse Three: '1200 fluid restriction and daily weight.'

The content of this passage illustrates the vague and ambiguous nature of the information exchanged. The main message is confusing and unclear. This was not the only passage in which the content or main themes were difficult to interpret.

Data were also analysed to address the frequencies of information conveyed within the various categories. In the 'Charting' category, once passages deemed to be irrelevant to ongoing patient care were excluded from the data, 93.5% of information discussed would or could have been recorded within the documentation system. The 'Charting' category included documentation that could have been in the medication chart (18%), progress notes (34%), nursing care plans (27%) and other (14.5%) structures (such as observation charts).

Of the 6.5% of information discussed, that could not be integrated into or obtained from some existing documentation source, 3.6% focused on issues concerning ongoing nursing/medical management, 1.2% was related to bed management and 0.7% was related to the patient's immediate location. Ward management issues, such as ordering of patient equipment/stores, accounted for 0.5% of relevant information discussed and 0.4% related to general communication issues. Information considered not to be relevant to patient care accounted for 9.5% of all handover discussion.

Nearly half (49%) of these discussions consisted of vague statements relating to the patients' conditions and 28% related to debriefing.

Discussion

The findings indicate that the majority of information (93.5%) discussed during the handovers observed is already available or should be available in the medical record or other documentation sources. This finding has important implications for the role of handover in ongoing patient management. Contrary to the popular belief that handover is essential to the continuity and consistency of patient care, some of the handovers observed in this study appeared to promote confusion and often did not clarify issues regarding patient status, treatments or management.

There are a variety of possible reasons for this. The haphazard nature of handover may be a direct reflection of the haphazard nature of the nursing shift. The chronic shortage of nurses may mean that nurses have to prioritize care on a shift-by-shift basis, performing only the essential tasks and neglecting the 'minor' ones. Tasks being neglected or omitted may include updating patients' care plans, therefore the need for a lengthy, convoluted handover.

The nursing shortage may have resulted in 'casual' nurses being utilized when necessary. As these nurses are working a 'one off' shift, they may also only focus on the essential care and do what they have to do 'to survive' or to 'get through the shift'. The nursing shortage may also mean that there is a lack of a 'dominant ward nurse' who is employed primarily to ensure quality of patient care. The nurse providing the 'direct' patient care may purely focus on the 'here and now' and fail to see or critique the long-term patient goal or outcome. A dominant figure such as a senior nurse practitioner could spend the time updating care plans and ensuring quality of documentation in the progress notes, both nursing and medical. If this were the case, each incoming nurse would have to spend considerable time at the start of the shift reading this information. Realistically, this amount of 'spare time' is often not available at the start of a shift. However, if documentation sources were kept up to date and the content clear and concise, the time spent in handover could be shortened and the remaining time spent reading the essential documentation.

The lack of clear and concise guidelines may also be responsible for the 'random nature' of handover content. Without guidelines, nurses may report anything and everything, or that which they perceive to be important and which may or may not be relevant to the

incoming nurses. If guidelines outlining what should be presented at handover and what should be written in the nursing notes were available, the length of handover may be reduced and the quality improved. This highlights areas for further research. A comparison of wards that have structured handovers with wards that do not, could be performed to determine the impact structured handover has on patient care and on job satisfaction. A study could also be performed on wards that have guidelines for handover and for documentation to determine if handover is necessary at all.

This study has some limitations. Throughout the recorded handovers it was apparent that more than simple information exchange was occurring. This is supported by the literature (Monahan *et al.* 1988, McMahon 1990, Parker *et al.* 1992, Wiltshire & Parker 1996, Kennedy 1999) which suggests the nursing handover is a complex phenomena involving elements of transfer of clinical information, socialization, debriefing, containment of anxiety and ritual. By breaking passages of speech into discrete categories, much of the context of the speech is lost and deeper, richer processes obfuscated. While this richness of the data is recognized, this study was based on content analysis to code information for the purpose of exploring explicit content.

The coding structure, while reflective of documentation processes within the study ward, is also representative of only one ward in one Australian hospital. Documentation and handover systems may follow different formats or have different guidelines in different wards, hospitals or countries. The coding structure is also new and previously untested. Future research could explore the use of this or similar coding structures in different hospitals and geographical regions. A further limitation is that specific documentation sources, such as progress notes, medication charts and nursing care plans, were not actually checked to determine their content. In this study, we only consulted five senior nurse practitioners to ascertain their opinion on existing ward documentation.

Conclusion

Current literature suggests that the content of shift handovers is irrelevant to patient care. However, the majority of these reports are anecdotal. Few, if any studies have examined handover content through a process of systematic content analysis. Our study contributes to the existing knowledge base by confirming what the literature, to date, has only hypothesized or speculated, namely that the majority of information presented in handover could or should be available in formal docu-

mentation sources. The implication of this knowledge to the nursing profession is that concise guidelines regarding the process and content of nursing handovers may help reduce the amount of unproductive time spent in handover, by ensuring that only essential information is 'passed on'. By reducing the amount of time spent in handover more time can then be spent in direct patient care.

We also found that some of the handovers observed in this study appeared to promote confusion and often did not clarify issues regarding patient status, treatments or management. Our findings provide strong evidence for reappraisal of the continuing role of handover in an increasingly complex health care environment. Intangible functions such as debriefing and socialization, whilst valuable, go only some way to justifying resources dedicated to the process, not to mention the potential for error. Other authors (Richard 1988, Parker *et al.* 1992, Sherlock 1995) have questioned the ability of nurses to retain the large volume of complex information delivered and assess information accuracy and relevance to ongoing patient focused care.

Improvement to the structure and delivery of handover, such as clear discussion boundaries and/or utilization of documentation sources, may eliminate the problems identified in this study and the published literature. For example, redundancy of reporting, confusion, accuracy, patient stereotyping or lack of relevance. The question remains however, that if this information is already available, is it necessary to repeat it orally or even on purpose-designed written handover sheets?

Reference to written documentation at shift commencement, as described by Wallum (1995) and Kennedy (1999), may be one way to eliminate many of the problems associated with an oral handover. Written handover may lead to an increased focus on ensuring accurate and thorough nursing documentation and improved utilization of nursing care plans, as these become the primary focus for patient care delivery (Wallum 1995, Kennedy 1999). There would be a reduced opportunity for error as nurses will no longer need to rely on memory to inform the following shift of medication and/or treatment regimes. Furthermore, nurses will be compelled to consult medication charts, nursing care plans and patients' progress notes prior to care delivery, resulting in greater consistency of care delivery (Monahan *et al.* 1988, Kennedy 1999) and again less opportunity for error.

The literature suggests that hospitals or wards tend to have their own preferred style of handover. There is a lack of specific guidelines in the literature for what should be included in the handover content. This may be the reason why so much time is spent giving and

thus listening to the report. Furthermore, if nurses are reporting what is already or should be documented elsewhere, 'streamlining' the handover could make it more useful and time efficient for the incoming nurses.

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