Challenges of Nursing Handover: A Qualitative Study

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Challenges of Nursing Handover: A Qualitative Study

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Abstract
The aim of this study was to explore the challenges of nursing handover process during shift rotation in hospitals. The research had a descriptive exploratory design with a qualitative content analysis approach. To conduct the study, three pediatric wards were selected at first. Data were gathered through a 4-month observation of nursing handovers by recording the oral conversations of nurses during the process and semistructured interviews. Then, qualitative content analysis was used for data analysis. Two major themes and five subthemes emerged through the data analysis. The first and the second themes were a nonholistic approach and poor management, respectively. In general, applying a holistic approach and managing handover situations are recommended for nursing managers to overcome handover challenges. Future focus could be on addressing handover challenges through an action research study.

Keywords
handover, nursing, content analysis

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**Introduction**

The nursing change of shift report or handover is a valuable opportunity to transfer responsibility and accountability from one nurse to another in most hospital wards (Lamond, 2000). It is actually a substantial part of a nurse’s duty, and each nurse should allocate 38% of his or her working hours in a hospital ward every day to fulfill the handover process (Spanke & Thomas, 2010). Therefore, handover is a fundamental component of nursing care for a nurse to pass on patients’ care plan, practices, information, and priorities to the next (Rushton, 2010). Moreover, handover is an opportunity for nurses’ group cohesion, professional socialization, education, interaction, and emotional support (Griffin, 2010; Payne, Hardey, & Coleman, 2000). Thus, handover should be accurate, complete, specific, relevant, timely, up to date, subjective, and objective. However, cases of handover that are inaccurate, incomplete, and biased may lead to many errors, mislead nursing practices, and increase patient complications (Rushton, 2010; Strople & Ottani, 2006).

A key component in patient safety and care quality is accurate communication during handover (Chaboyer, 2011). The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has established standardizing handover as a priority for improving patient safety since 2006 (Chaboyer, 2011; Schroeder, 2006). However, a review of literature reflects limited research and articles addressing handover, while most of them highlighted the importance of nursing handover and prioritized it for patient safety (Baker, 2010; Blouin, 2011; Schroeder, 2006; Scott, 2012; Welsh, Flanagan, & Ebright, 2010).

Although there are controversies about the efficacy of handover practices, some articles highlight the importance of oral shift report that could not be substituted by any other method because handover is the only place where different aspects of professional nursing care are identified (Gordon & Findley, 2011; Manias & Street, 2000; Scovell, 2010); otherwise, other studies question its efficacy and report that there is no need to have an oral shift report because most of the discussed information could be located within nursing documentation, and, therefore, such a practice is time-consuming (Manias & Street, 2000; Sexton et al., 2004).

In practice, the complexity of patients’ conditions, lack of organization, and different interruptions during handover prolong the reporting process (Spanke & Thomas, 2010). In a large scale study of 10 European countries, Meißner et al. (2007) explored the nurses’ perception of handover and the reason for dissatisfaction among them. She found that 22% to 61% of nurses were dissatisfied due to “too many disturbances,” “lack of time,” and “work organizational factors” (Meißner et al., 2007).
In general, the goal of nursing handover is the transfer of relevant information and continuity of patient care; however, there is no agreement about its content and the related literature recommends different templates for presenting data (Johnson, Jefferies, & Nicholls, 2012). According to Schroeder (2006), the specific component of shift report should include PACE (Patient problems, Assessment/Action, Continuing/Changes, Evaluation; Schroeder, 2006), and other researchers have suggested other templates such as SBAR (Situation, Background, Assessment, and Recommendations; Raines & Mull, 2007). Regarding all such guidelines, the content of handover must contain short- and long-term goals. It should also be broad and specific enough to meet the patients’ needs. Furthermore, it should contain information such as medical and nursing care and physical, psychosocial, spiritual, and family needs at the same time (Rushton, 2010).

A body of literature reflects four modes of handover: the verbal handover in station, tape recording, written handover, and handover at bedside. In practice, the method of handover depends on the patient, the shift (day, evening, or night shift), and the model of service delivery (team vs. case method; Johnson & Cowin, 2012). Nevertheless, many studies have confirmed the efficacy of bedside handovers. (Chaboyer, 2011; Chaboyer, Johnson, & Wallis, 2009; Mott & Bradley, 2010; Webster, 1999) For example, Mott and Bradley (2010) conducted an action research in three rural South Australian hospitals and incorporated bedside handover reports. She found that bedside handover was better than office reports in terms of ease and time efficiency. Interestingly, level of satisfaction increased among nurses and patients, and patients were more involved in their care; it also decreased the rate of errors (Mott & Bradley, 2010).

The role of nurses and families has changed recently in pediatric wards; previously, all responsibilities were done by professional nurses, but now, complete involvement of family is highly supported (Hutchfield, 1999; Mikkelsen & Frederiksen, 2011). The words nurses use in describing a family during shift report can affect how other nurses approach a family. Although the goal of shift report is to exchange objective data, value judgments and labels often accompany these data. These labels can limit the opportunity of families to learn the skills needed to manage the problems and meet their essential needs and decrease their involvement. So, applying a standard handover is essential in pediatric wards (Ryan & Steinmiller, 2004).

The first step in standardizing handover and introduction of an alternative model is to improve our understanding of current practices. Although some studies have been conducted in several countries, the handover practices have not been well studied in the Iranian health system because the context is different. Because situational analysis is the first step in changing the program,
exploring the current conditions of handover is important. Hence, the aim of this study was to explore the challenges of handover practices in Iran to provide an opportunity for a better understanding of the situation and help improve the current practices.

Method

Design

The study was conducted using a descriptive exploratory qualitative design with a content analysis approach. Content analysis is a way to analyze written, verbal, or visual information. It actually serves as an action guide and aims at providing valid insights from data to attain a broad and complete description of a phenomenon (Cole, 1988). In this research, an inductive approach of content analysis was used. In this method, categories are derived from data during data analysis, which help to attain a richer understanding of a phenomenon. Another approach we used during the analysis was summative content analysis. This approach is fundamentally different from the previous one in that rather than analyzing the data as a whole, the text is often approached as a single word or in relation to a particular content and word frequency is calculated manually or by a computer (Hsieh & Shannon, 2005).

Data Collection

Three pediatric wards in Shiraz in the south of Iran were selected. We gathered multiple sources of data such as observations, interviews, and recordings of oral shift reports. During 4 months of observation period, 14 handovers (5 in the morning, 5 in the evening, and 4 at night) were observed and tape-recorded. Observations were noninterventional and semistructured, focusing on the key events and activities during handovers. Field notes were written immediately after each observation. Then, the records were transcribed verbatim and a sample of 130 patient reports was subjected to summative content analysis. A coding framework was used to calculate the type and frequency of information exchanged during nursing handovers. Word frequencies of oral shift reports were calculated manually. In addition, nine in-depth interviews were conducted with the nurses, who were selected through a purposeful sampling. We continue sampling until we have reached saturation. The inclusion criteria were availability and willingness to complete the interview. A guide was prepared for covering key questions that were general with prompt to encourage responses during the interviews. Examples of interview questions include the following:
Can you describe today’s handover, what are the problems with the handover? How do you deal with these problems? Can you provide any examples? Would you like to make see any changes? If so, what would they be? All interviews were conducted and recorded in a quiet location, and each lasted between 30 min and 45 min.

**Ethics**

The ethics committee of the university approved the project. Before each interview, the participants were informed of the aim and method of the study and that their participation was voluntary. Besides, they were told that they could leave the study at any time they wished. Confidentiality was ensured so that no names were mentioned. On top of that, a form was signed by the participants saying that they were informed and consented to the study.

**Analysis**

Inductive and summative content analyses were used to explore the challenges of nursing handover practices. Content analysis may be used in an inductive or deductive way. However, while in inductive content analysis, the categories are derived from the data, in deductive content analysis, the data are categorized according to previous knowledge or theory (Elo & Kyngas, 2007). The oral shift report-taped handovers, interviews, observations, and field notes were transcribed after each section of data collection. At first, data were approached by being read as a whole repeatedly before being read word by word to achieve immersion and finally to derive codes. Then, we organized and grouped the codes into meaningful clusters. For the purpose of abstraction, the relationships between categories were identified, and two major themes emerged. The researcher returned to the codes and reconsidered them to check whether the themes fit the data again. A second researcher read the categories and themes for further refinement. MAXqda2 software was used for data analysis.

**Trustworthiness**

The procedures that were used to improve trustworthiness were as follow: Coding and categories were sending back to the participant for possible revision. A team-based approach (composed of four qualified nurses in qualitative research) to analyze data was established to check the credibility. It showed a good level of agreement in interpretation, and some disagreements were resolved through discussion. Prolonged engagement,
varied experiences, peer checking, and triangulation were other strategies for improving the trustworthiness of the study (Helen & Carpenter, 2007; Polit, Bech, & Hungler, 2006).

Findings

All the nurses were female with a mean age of 30.1 ± 6.8 years and mean experience of 6.9 ± 5.6 years, and all have bachelor’s degree in nursing.

Data analysis resulted in identification of two major themes and five subthemes. The first theme was a nonholistic approach, and the second one was poor management. These are presented in Table 1 and are explained in the following section.

Nonholistic Approach

The first theme emerged from data included nonholistic approaches in nursing handover practices. The subthemes were nonholistic/unstructured content, low nurses ethical and practical involvement, and non-patient-centered approach, which are explained separately in the following section.

Nonholistic/unstructured content. Summative content analysis of 130 patients in the oral shift report showed that the contents of nursing handovers were not holistic. The total frequency with which information was mentioned in nursing handover can be seen in Table 2. This table illustrates that medical plans and physical dimensions are more dominant, and nursing care plans and other aspects of patient care such as psychosocial, functional, spiritual, and family needs are almost unheard-of. In addition, as can be seen in the following shift report, the focus was on medical plans and physical dimensions so that the reports were not holistic:
## Table 2. Frequency of Information Presented in Patients’ Report.

<table>
<thead>
<tr>
<th>Information</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>130</td>
<td>100</td>
</tr>
<tr>
<td>Age</td>
<td>25</td>
<td>19.2</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>54</td>
<td>41.5</td>
</tr>
<tr>
<td>Contextual information</td>
<td>21</td>
<td>16.1</td>
</tr>
<tr>
<td>Date of admission</td>
<td>11</td>
<td>8.4</td>
</tr>
<tr>
<td>Medical history</td>
<td>29</td>
<td>22.3</td>
</tr>
<tr>
<td><strong>Physical status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory function</td>
<td>10</td>
<td>7.6</td>
</tr>
<tr>
<td>Consciousness</td>
<td>7</td>
<td>5.3</td>
</tr>
<tr>
<td>Discomfort</td>
<td>11</td>
<td>8.4</td>
</tr>
<tr>
<td>Urine</td>
<td>16</td>
<td>12.3</td>
</tr>
<tr>
<td>Diet</td>
<td>37</td>
<td>28.4</td>
</tr>
<tr>
<td>Vomiting</td>
<td>10</td>
<td>7.6</td>
</tr>
<tr>
<td>Bleeding</td>
<td>11</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Physical measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>22</td>
<td>16.9</td>
</tr>
<tr>
<td>Temperature</td>
<td>33</td>
<td>25.3</td>
</tr>
<tr>
<td>Fluid input</td>
<td>32</td>
<td>24.6</td>
</tr>
<tr>
<td>Weight</td>
<td>16</td>
<td>12.3</td>
</tr>
<tr>
<td><strong>Nursing intervention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient care need</td>
<td>37</td>
<td>52</td>
</tr>
<tr>
<td>Nursing care plan</td>
<td>28.4</td>
<td>40</td>
</tr>
<tr>
<td><strong>Medical treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultations</td>
<td>25</td>
<td>19.2</td>
</tr>
<tr>
<td>Medications</td>
<td>72</td>
<td>55.3</td>
</tr>
<tr>
<td>Surgical intervention</td>
<td>8</td>
<td>6.1</td>
</tr>
<tr>
<td>Tests</td>
<td>57</td>
<td>43.8</td>
</tr>
<tr>
<td>Plan of care</td>
<td>46</td>
<td>35.3</td>
</tr>
<tr>
<td>Doctor orders</td>
<td>16</td>
<td>12.3</td>
</tr>
<tr>
<td><strong>Global judgments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient condition</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>About care</td>
<td>9</td>
<td>6.9</td>
</tr>
<tr>
<td>Psychology/personality</td>
<td>9</td>
<td>6.9</td>
</tr>
<tr>
<td>Colleagues</td>
<td>28</td>
<td>21.5</td>
</tr>
<tr>
<td><strong>Management issues</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient transfer</td>
<td>12</td>
<td>9.2</td>
</tr>
<tr>
<td>Admission</td>
<td>3</td>
<td>2.3</td>
</tr>
<tr>
<td>Discharge</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>General</td>
<td>30</td>
<td>23</td>
</tr>
</tbody>
</table>

(continued)
X, X was well too, she didn’t have any convulsion, the physician changed the Phenobarbital and Dilantin to PO ones. She didn’t have any sample to send to laboratory; we didn’t have any problems with her.

Furthermore, analysis of tape records represented that nursing handover did not have a structured content. Different presentation styles, irregular body, and incomplete wrap up and narration are the categories emerging from data analysis. The following excerpt illustrates that the unstructured content of the report leads to missing information:

Incharge: Miss X, Do you know her?! Head nurse: Yes. Incharge: X was well too, she is NPO for MRI; she had Doppler Sono yesterday, and its result is in her file. She is ok and doesn’t have any problem. Next patient Y, Head nurse: Does previous patient have EEG for today? Incharge: Oh, yes of course, I forgot to mention it.

Nurses’ low ethical and practical involvement. Another subtheme pertaining to nonholistic approach is nurses’ low ethical and practical involvement. Data obtained from multiple sources indicated that in spite of the case method caring system, the nurses did not have an active role in the handover process and those in charge are the only individuals who have the whole responsibility. The following field note and interview showed low practical involvement of nurses during handover processes:

Observation 4: One evening, after checking the emergency and narcotic boxes, two Incharge sat on chairs in the station and oral shift report started while other nurses were preparing medications or speaking with each other in the station.

In another case, one of the head nurses in the interview stated that

<table>
<thead>
<tr>
<th>Information</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care need</td>
<td>15</td>
<td>11.5</td>
</tr>
<tr>
<td>Comprehensions</td>
<td>8</td>
<td>6.1</td>
</tr>
<tr>
<td>Functional status</td>
<td>5</td>
<td>3.8</td>
</tr>
<tr>
<td>Psychological</td>
<td>3</td>
<td>2.3</td>
</tr>
<tr>
<td>Social</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Spiritual</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
In the handover process, all of the responsibilities are for the one in charge and other nurses don’t have an active role in this process, and speak with each other or do other things, while they must have an active role and listen to reports carefully to be informed about patients’ conditions.

In addition, data from observation and tape records showed that nursing handovers were not completely ethics-based. Labeling patients, prejudgments, and inattention to patient and their families’ demands were the categories that emerged from the data. The following excerpts illustrate that nurses labeled patients and had prejudgment about patients and their families:

Visitor of X made us nervous; she has a mental problem. She came every 30 minutes to the station and asked different questions about her child.

X is a 2-year-old girl that was transferred here from ICU yesterday; she was opium poisoned. The nurse of the new shift said: Definitely her family gave her the opium, didn’t they?!

Summative content analysis, as shown in Table 2, also shows that frequency of prejudgments about patients, families, and colleagues were high in nursing handover contents.

**Non-patient-centered approach.** The findings showed that nursing handovers are non-patient-centered. Observations revealed that the average time taken for handover was 41 min for each shift, only 9 min of which was allocated to bedside handover (42 s for each patient on average).

Observation 8: In the second room, the nurses entered while speaking with each other; one of them approached the patient and assessed the IV sheets and its date. Then without saying anything she went to another patient. This took 50 seconds.

As you see, we categorized these subthemes—nonholistic/unstructured content, nurses’ low ethical and practical involvement, and non-patient-centered approach—in one group and subsequently labeled it as nonholistic approach.

**Poor Management**

The second theme that emerged from the data is poor management during nursing handover practices. Subthemes were poor time and space management and poor task management.
Poor task management. Data obtained from multiple sources in this research showed that nurses encountered task overlap and work overload during handover processes.

One of the head nurses in the interview said,

Job description is not clear during handover processes, so during this process nurses should do many tasks simultaneously such as checking the equipment and utensils, preparing medications, answering telephones, responding to visitors, completing the notes of patients or doing other stuff such as discharging or admitting new patients.

Poor time and space management. Data from interviews and several field observations also suggested that the time and space of handovers were not well managed. Poor time management, hasty reports, too many interruptions, crowded stations, and no seats to participate in handovers were the categories.

The results of observations showed that handover lasts for about 41 min, but time management of the process is not appropriate; at first, they check the equipment such as emergency trolley, the narcotics box, and other utensils for about 12 min. Then they listen to the oral shift report in the station for about 26 min and then have a round in patient rooms for about 9 min, approximately 42 s for each patient. These data suggest that time management was poor, and in this regard, a nurse said,

We should check the equipment carefully because if something is lost, we must pay for it, so it takes a long time to check them; as a result, we report in a hurry and many important things might be missed.

Or another nurse in the interview said,

We don’t have a place for handover; in the station there are many people such as medical and nursing students, physicians and other nurses. When we are reporting, we should answer phone calls, questions from families and physicians and in the meanwhile focus our mind to report, and it is impossible. There are many distractors that lead to inattention.

As can be seen, we categorized these subthemes—poor task management and poor time/space management—in one group and labeled it as poor management.

Discussion
The aim of this study was to explore challenges of nursing handover practices in Iran. The findings indicate that there are various challenges in handover
practices in nursing, and, therefore, it seems essential to explore these challenges in our health system. Data analysis resulted in identification of two themes that explain challenges of nursing handover practices, namely, non-holistic approach and poor management during nursing handover.

Findings showed that nursing handover practices were not holistic because the contents of report were not holistic and structured. The nurses’ ethical and practical involvement was low and non-patient-centered. Literature suggests that the content of handover should contain information such as physical, psychosocial, spiritual, medical, and nursing care and family needs at the same time (Rushton, 2010). However, nursing handovers in the studied wards lack such holistic approaches, and medical and physical needs are dominant. This fact is confirmed by other studies in our country. Irajpour, Alavi, Abdoli, and Saberizafarghandi (2012) and Yektatalab, Kave, Sharif, Fallahi Khoshknab, and Petramfar (2012), in two qualitative studies, showed that health care in Iran is based on “Medical Paradigm” in which professionals treat the clients as biological entities, that is, they pay all their attention to meet the clients’ biological deficits and needs, thereby neglecting many aspects of care such as educating patients. According to Moattari, Ebrahimi, Sharifi, and Rouzbeh (2012), ensuring adequate access to education for all patients is a clear challenge (Moattari et al., 2012). Other findings showed that health professionals who follow medical approach may neglect the clients’ nonbiological (i.e., psychosocial) needs and problems (Irajpour et al., 2012; Yektatalab et al., 2012). In addition, Momennasab, Moattari, Abbaszade, and Shamshiri (2012) highlighted the importance of attention to spiritual needs of patients in a religious context such as the Iranian society (Momennasab et al., 2012). Medical paradigm in our country is dominant and leads to medical oriented approach in nursing practices even in nursing handovers (Hagbaghery, Salsali, & Ahmadi, 2004). In addition, Ekman and Segesten (1995) stated that “nurses receive deputed power of medical control and little attention is paid to nursing needs during handover” (Ekman & Segesten, 1995, pp. 1006-1011). Nikbakht, Juliene, and Emami (2004) highlighted this medical oriented paradigm and explained that it could be due to the patriarchal social structure in Iran, because the most respected health care provider is an experienced, male physician (Nikbakht et al., 2004).

Emami and Nikbakht, in a qualitative study in 2007, showed that nurses in Iran work based on task-orientated approach. This appears to be due to nursing curriculum in Iran whose focus is on a biomedical and task-orientated approach. Therefore, it affects how nurses prioritize their working tasks (Emami & Nikbakht, 2007). As Nikbakht et al. (2004) suggested, schools of nursing must prepare students to deal with the consequences of conflicting models by
helping the faculty revise the curriculum to reflect a creative and culturally based philosophical perspective (Nikbakht et al., 2004).

Our findings showed that the current handover practices do not have an organized structure, and this is one of the challenges that lead to many problems such as lack of concentrations and missing or forgetting important information, while structural contents of the report allow meaningful organization of large amounts of data (Yurkovich & Smyer, 1998). Dowding (2000) conducted an experimental study to assess the effects of changing the style and content of the nurses’ report on nurses’ ability to plan patient care. Results indicated that such type of report had a significant effect on nurses’ ability in planning patient care, accuracy of information and the ability to recall the information they heard (Dowding, 2000). Therefore, providing a template for presenting patient information may increase the quality, accuracy, and speed of handovers. Analyses of multiple sources of data showed that handover process is not a collective action. Moreover, nurses’ ethical and practical involvement was low, and they had an inactive role in this process. Inadequate nursing staff may cause this situation in nursing handovers in Iran because some of the nurses should check and prepare the medications, some of them should listen to oral shift reports, and others should go to patients’ rooms for monitoring IV sites and sheets. Furthermore, the nurses know that the ones in charge have the whole responsibility and should listen to the reports carefully to transfer the important information to other nurses, so they do not participate in this process actively. Yektatalab, Kave, Sharif, Fallahi Khoshknab, and Petramfar (2011) believed that this impaired care is due to nursing shortage, lack of competent nurses, high workload, lack of job security, and low salaries in Iran (Yektatalab et al., 2011).

While literature and studies emphasize the collective function of handovers (Ekman & Segesten, 1995; Scovell, 2010; Strople & Ottani, 2006), this process was not so in the studied wards. Handovers provide an opportunity for professional communication, supporting role socialization and development of a cohesive group process (Yurkovich & Smyer, 1998). Unfortunately, studies in our country show that teamwork in our society and health care system are poor and need to be improved (Mojdeh, Memarzadeh, Abdar Isfahan, & Gholi Pour, 2009; Tafreshi, Pazargadi, & Abed Saeedi, 2007). In addition, Meiβner et al., 2007 found that “poor support from colleagues” was a reason for dissatisfaction during shift handover in Europeans nurses (Meiβner et al., 2007).

However, we found that handovers can become vehicles for gossiping and labeling each other, with the potential for undermining the relationships and trust among nurses during handovers. This finding is consistent with the result of Payne et al. (2000) indicating that these judgments are
frequent in handovers (Payne et al., 2000). Code of ethics in Iran was formulated in 2010, but to achieve more, it seems essential that we compile codes of nursing ethics at different levels of nursing practices such as nursing handovers and educate nurses in workshops and seminars (Sanjari, Zahedi, & Larijani, 2008). The American Nurse Association code of ethics for nurses recommends the value of a guide to nursing handover (American Nurses Association, 2001); however, because Iran is an Islamic country, and gossiping, labeling, and prejudgments are taboos based on teachings of the religion, it is undoubtedly necessary to provide a national code based on our sociocultural norms in this field. Nursing in Iran is perceived as a holy and honorable job, so Islamic principles provide a promising guide to ethical codes of nursing taking Iranian culture and religion (Larijani, Zahedi, & Malek-Afzali, 2005; Nikbakht, Emami, & Parsayekta, 2003; Sanjari et al., 2008).

Another important aspect of the holistic approach in nursing handover is patient-centered care. Our study showed that patient participation was low and they were mostly passive onlookers, while the findings of McMurray, Chaboyer, Wallis, Johnson, and Gehrke’s (2011), which examined patient perspective of nursing handover in Queensland hospitals, showed that patients valued having access to information and considered themselves an important part in maintaining accuracy that improves safety and quality (McMurray et al., 2011). Nowadays, patients desire to move from a parent model of care to a collaborative model of care, especially in pediatric wards that focus on family-centered care (Anderson & Mangino, 2006; Hutchfield, 1999; Mikkelsen & Frederiksen, 2011). Like many Asian countries, Iran is a family-oriented society, so family members express concern about the patient’s problem and provide support for their loved ones (Moattari, Hashemi, & Dabbaghmanesh, 2013). The results of our study showed that patients’ and families’ participation is ignored. Vasli, Salsali, and Tatarpoo (2012), in a qualitative study in Iran, assessed the perspectives of nurses on barriers of parental participation in pediatric wards. Four main themes emerged as barriers of parental participation in pediatric care, namely, mutual motivation and interest in parties, lack of support for nurses, nursing shortages, nurses’ workload, and poor teamwork between nurses and physicians, confidence in the nursing profession, and finally undefined role for mothers (Vasli et al., 2012). Timonen and Sihvonen (2000) interviewed families and found that main reason for them not participating during handover were lack of encouragement, nurses concentrating on their papers, using special language, and lack of time (Timonen & Sihvonen, 2000). Thus, we should consider these findings to improve and strengthen parental participation during handovers.
Another theme that emerged from our data was poor management. Based on the results of this study, time and space management during handovers is poor. Baldwin and McGinnis (1994) reported that prolonged verbal reports lead to nurses’ inability to prioritize patient needs (Baldwin & McGinnis, 1994). In our study, nurses had to allocate some time for checking the equipment, so the time allocated for patients decreased due to the priority of checking the equipment due to economic considerations. It is actually because some equipment is rare and expensive, and hospitals expect nurses to maintain them as well as possible. Furthermore, too many interruptions during handovers lead to inattention and prolonging the process as well.

Another challenge was allocation of space. Locating an area far from interruptions and patient’s confidentiality and privacy is an essential aspect of handovers, and the best option depends on the context (Yurkovich & Smyer, 1998). In these wards, there was not a quiet room for handovers, leading to many interruptions during handovers, which in turn decrease the quality and accuracy of handover. In addition, Nikbakht and Emami (2006) found that institutional circumstances are an issue for nurses in Iran. Welsh et al. (2010) found the same result as the current study. Their analysis showed that inadequate information, inconsistence quality, limited opportunity to ask questions, equipment malfunction, insufficient time to generate reports, and interruptions limited handovers (Welsh et al., 2010).

Task overlap was another problem that interfered with handovers. During handovers, the nurses should do many tasks simultaneously. Task overlap leads to inattention that will cause many errors during oral shift reports. Lack of definite job description for nurses during handovers in our health system is the key reason for such task overlap. Mayor, Bangerter, and Aribot (2012) found that mean handover duration per patient increased with increasing task uncertainty, and they recommended that redesigning of handover procedure should take task uncertainty into account (Mayor et al., 2012). A qualitative study conducted by Nikbakht et al. (2003) supported the finding that work pressures, insufficient time, and lack of resources hindered nurses from doing their work (Nikbakht et al., 2003).

However, our study has some limitations that should be considered. The study took place in pediatric wards, so there are limitations for generalizing our findings to other clinical settings. Thus, it is recommended that further studies be conducted in other wards. Furthermore, although we had field observations, we may miss other challenges although we have reached saturation. Despite these limitations, the findings captured a good picture of the current situation to better understand the current nursing handover practices and provide a foundation to plan and implement appropriate change.
Conclusion

Qualitative and quantitative analyses are ways to reach a better understanding of the challenges of nursing handovers. In general, analysis of multiple sources of data indicated that nursing handover process had many challenges that need to be modified. Applying a holistic approach (designing a holistic content, encouraging nurses’ participation, and involving patients) and managing the handover process (determining job description and allocating specific time and space) are some strategies for improvement. The findings of the present study challenge nursing managers to develop new strategies that can improve nursing handovers, which can in turn facilitate changes that increase the nurses’ level of work satisfaction; as a result, these can lead to a higher level of patient safety with a higher quality of care. Nursing handover is a skill that requires education and practice, so, in this regard, in service education is highly recommended. Because standardization of handover practices completely depends on the context (culture, philosophy, needs, facilities, priorities, and economic considerations in each organization are different), future focus could be on addressing handover challenges through an action research study in which the identified problems will be addressed by including those who are part of the process to act on their own behalf to solve real-world problems.

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Authors’ Note

R.S.S. was responsible for the study conception and design. R.S.S. performed the data collection. R.S.S. and M. Moattari performed the data analysis. R.S.S., M. Momennasab, S.H.Y., and A.N.N. were responsible for drafting the manuscript. R.S.S., M. Moattari, M. Momennasab, S.H.Y., and A.N.N. made critical revisions to the article for important intellectual content. M. Moattari obtained funding. M. Moattari, M. Momennasab, S.H.Y., and A.N.N. gave administrative, technical, or material support. M. Moattari and A.N.N. supervised the study. This paper is a part of PhD dissertation of Raheleh Sabet Sarvestani.

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