

**TITLE PAGE**

**Title:** Family Members' Perceptions of the Nursing Bedside Handover

**Article Type:** Original Article

**Corresponding Author:** Georgia Tobiano

**Corresponding Author's Institution:** Griffith University

**Order of Authors:** Georgia Tobiano, RN, BN (Hons); Wendy Chaboyer, RN, PhD, FRCNA;

Anne McMurray, AM, RN, PhD, FRCNA.

## **ABSTRACT**

**Aims and objectives:** To explore families' perceptions of shift-to-shift bedside handover.

**Background:** The potential role families can play in bedside handover is unknown.

Understanding family members' perceptions can provide a foundation for nurses to tailor their bedside handover to family members' perceptions, encouraging their involvement and potentially improving patient care.

**Design:** Qualitative study, using case study methodology.

**Method:** The study was conducted with eight family members in one rehabilitation ward in Queensland, Australia in 2009. Data included observations of bedside handover, field notes and in-depth interviews. Thematic analysis of data was conducted to identify unique and common themes indicative of family perceptions.

**Results:** Three major themes emerged. The first, understanding the situation, consisted of three subthemes: feeling informed, understanding the patient's condition and understanding patient's treatment. The second theme was interacting with nursing staff, with five subthemes, including sharing information, clarifying information, assisting in care, asking questions and interpreting for the patient. The final subtheme was finding value, which contained five subthemes: feeling at ease, feeling included, valuing individualization, preparing for the future and maintaining patient privacy.

**Conclusions:** Bedside handover provides an opportunity to involve family members in patient care and promote family-centred care core concepts. Family members value the chance to participate and can ultimately improve the accuracy of handover communication.

**Relevance to clinical practice:** Bedside handover is beneficial for nurses, patients and family members and embodies patient and family-centred care. Managers should consider its

implementation in hospitals, developing strategies such as standard operating protocols for a more family inclusive approach to communication. Nurses may require further training to best undertake bedside handover and involve family members in care. The study suggests expansion of research into this important area of family centred care

**Keywords:** Nurse, bedside, patient, family, quality of care, communication.

**Word count:** 4,355

## **INTRODUCTION**

Communication failures are the leading cause of patient harm (Leonard *et al.* 2004) and are the root cause of 65% of sentinel or catastrophic events (The Joint Commission 2005).

Handover presents a common clinical situation where there is a high risk of miscommunication (Clancy 2008). Various studies have found inadequacies in the content of nursing shift-to-shift handover (Sexton *et al.* 2004, O'Connell *et al.* 2008, Welsh *et al.* 2010), sometimes related to clinical information about the patient being communicated incorrectly (Currie 2002, Fenton 2006, Riesenber *et al.* 2010).

One solution to the problem of missed or inaccurate information has been to conduct the nursing handover at the bedside (Chaboyer *et al.* 2009), so that patients and their families can contribute vital information (Kaufman 2008). Previous research has shown patients' support for this practice (Cahill 1998, Kassean & Jagoo 2005, Kelly 2005, McMurray *et al.* 2011), however, there is limited evidence on family members' perspectives of bedside handover. This study aimed to improve this gap in knowledge by examining family members' perspectives.

## **BACKGROUND**

Allowing patients and family members to participate in bedside handover presents an approach that is congruent with family-centred care (FCC) theory. In essence FCC is "...an innovative approach to planning, delivery and evaluation of healthcare, governed by mutually beneficial partnerships between the health professional, patient and family" (Institute for Patient- and Family-Centred Care 2010, p. 1). The four core concepts of FCC are dignity and respect, information sharing, participation and collaboration (Institute for Family-Centred Care 2008). Ultimately, undertaking a FCC approach could result in improved family and patient satisfaction (Fisher *et al.* 2008), reduced anxiety for the family (Polst & Nelson 2008)

and improved patient safety (Kaufman 2008). Yet, there is growing evidence to suggest that, although FCC represents an ideal approach to nursing practice, it is not being implemented well into the clinical setting (Wright & Bell 2004, Astedt-Kurki 2010, Saveman 2010).

In adult settings, researchers have found that not all nurses have interacted in a supportive way towards family members (Benzein *et al.* 2008). On the contrary, it is the family, rather than the nurse who tends to initiate interactions (Astedt-Kurki *et al.* 2001a, Astedt-Kurki *et al.* 2001b), reflecting family members' need for information that will be helpful in caring for the person hospitalized (Astedt-Kurki *et al.* 1997, Saveman *et al.* 2005, Van Horn & Kautz 2007, Almborg *et al.* 2009). Yet, for nurses, eliciting information from family members could yield invaluable clinical information.

**Bedside handover** presents an ideal opportunity for nurses to interact with family members. Evidence shows the merits of bedside handover, particularly in ensuring that the patient has the opportunity to convey any relevant information to nurses at the time of handover (Cahill 1998, Kassean & Jagoo 2005, Kelly 2005, Chaboyer *et al.* 2009, McMurray *et al.* 2011). Other strategies can also enhance the accuracy of information during handover. Standard operating protocols (SOPs) encompass standardised solutions, tools and strategies for the delivery of handover communication (Australian Commission on Safety and Quality in Health Care (ACSQHC) 2007). SOPs are based on the leading available evidence, created to advance systemic improvements, with the potential to reduce the risk of patient harm (ACSQHC 2007). One SOP for bedside handover recommends that family members should be allowed to stay during bedside handover and actively participate, with patients' permission (Chaboyer *et al.* 2008). This may ultimately enhance patient safety through better continuity of care and family members playing a role in the accuracy of information handed over (Kaufman 2008). Despite these recommendations, many handovers do not include patient and family contributions (ACSQHC 2008). Instead, patients and their family are often perceived

as a source of distraction, interrupting the handover (ACSQHC 2008). Although some hospitals have introduced bedside handover, no research has been done to reflect the perceptions of family members.

### **Aim**

Without knowledge of family members' perceptions of bedside handover, the potential role families could play in communicating may be limited, and as a result, their potential contribution to patient safety could be overlooked. The aim of this case study was to explore families' perceptions of the shift-to-shift bedside handover in one adult rehabilitation setting. Interpreting family members' personal experiences has the potential to draw attention to patient safety issues, highlight better ways to involve families in clinical communication and identify concerns to promote continuity of care.

## **METHODS**

### **Design**

The research approach was a single case study (Yin 2009) where data from individual family members represented 'mini-cases' or multiple units of analysis (Yin 2009). This approach allowed both within-case and cross-case analysis (Gangeness & Yurkovich 2006, Luck *et al.* 2006). In this study, the case was bound by place and situation, with the context being the single rehabilitation ward. The boundaries were defined by the event of bedside handover occurring at the day-to-afternoon nursing shift, which included visiting hours and the presence of family members.

### **Participants**

The study recruited a convenience sample of eight participants, who currently had family members admitted to one rehabilitation ward in a hospital in Queensland, Australia, in 2009. It was not a requirement of the study that family members had previous experience in the

handover, but they had to be willing to take part and be observed by the researcher during bedside handover. The sample was confined to eight people, once analysis showed that no new themes were emerging.

### **Data Collection**

Data collection involved interviews, observations and field notes. The observations of families' interactions occurred in the context of bedside handovers, which were undertaken prior to the interviews. The interviews were in-depth, semi-structured and audio-taped. Interviews were designed to encourage participants to relate their experiences in the deepest and richest way possible, to allow deeper understandings of their experience (Taylor *et al.* 2006). Interviews were conducted in various places around the ward such as the tea room, courtyard or patient dining room, to accommodate the needs of staff, participants and any events on the ward.

The interviews were conducted as a guided conversation. Questions were general, with prompts to encourage responses. Examples of interview questions included:

1. What do you think about nurses doing their shift-to-shift handover at your relative's bedside?
2. What do you think your role is in the bedside handover?
3. Are there issues you think should not be discussed during bedside handover? If so, what are they?

Field notes were recorded to substantiate observations, which captured non-verbal communication and interactions allowing the researchers to contextualise the data. The combination of both methods of data collection allowed triangulation of sources, which, in turn helped maintain rigour of the study findings (Yin 2009).

### **Data analysis**

Analysis was concurrent with data collection, which allowed ongoing review of the data and the sampling strategy. Audio-taped data were transcribed and discussed within the research team to ensure congruence in the identification of meaning. Coding and categorization of the transcripts occurred in the following way to develop major themes:

1. Level one: raw data were given labels using the words spoken by the participants (Taylor *et al.* 2006), which allowed data reduction and brought the text into more precise meanings;
2. Level two: the data were organised to form links and emerging subthemes and themes (Taylor *et al.* 2006); and
3. Level three: themes and subthemes were labelled and linked with other themes and subthemes, derived from level one and two, to sort the data into meaningful connections (Taylor *et al.* 2006).

Analysis of each transcript was undertaken separately. Through the repetitive reading and re-reading transcripts and listening to tapes, emergent themes were identified and coded. The identified themes were then compared with the data emerging from other transcripts, to identify unique and common elements. Field notes were analysed in conjunction with the transcripts to ensure congruent understanding of the themes.

### **Ethical issues**

Ethics approval was received from the University and the Human Research Ethics Committees of the Hospital. All participants were given an information sheet and signed a consent form.

### **Rigour**

The participants who volunteered to participate were provided with information on the purpose of the study and processes involved in data collection. All participants were deemed



to be credible as they were approached in their natural role of visiting the patient who was their relative. The context was considered appropriate due to the frequent involvement of family members and use of bedside handover on the ward. Joint discussion of the emerging analysis also ensured common understandings by the researchers as well as family members. Auditability was ensured by explicitly describing and reflecting on the analytical steps at each stage of the study (Nelson 2008). This ongoing reflexivity was an important mechanism for identifying unique and shared meanings emerging from the data, as distinct from individual preconceptions or expectations of the data (Holloway & Wheeler 2002).

## **RESULTS**

The participants were eight females, as no males volunteered for the study. Four participants were patients' wives, with the remaining four being patients' daughters. Six participants had been involved in bedside handover prior to the day they were observed and interviewed, while the remaining two reported it being the first time they were present during the bedside handover. Five patients were hospitalised due to suffering a stroke, while the other three had orthopaedic conditions. They had been hospitalised for 14-45 days (median 24.5 days). The analysis revealed three themes (see Table 1).

### **Understanding the situation**

The theme understanding the situation was comprised of three subthemes all of which contributed to a deeper understanding. In the first subtheme, feeling informed, family members outlined the importance of being allowed to listen to the information communicated between nurses. Bedside handover provided a sense of ease as family members did not have to disrupt nurses during the shift to find out information:

*I think it's great, really, because I get to hear what they're talking about and it helps me to be informed and I like to be informed and know what's going on. Because nothing's worst than being left out as a family, like you're just sitting there and you*

*don't know, you've got to drag someone out and ask questions. Whereas that's good, it's practical and it's helpful.*

The next subtheme, understanding patient condition, showed that family members sought an in-depth explanation of the patient's situation, whether it was an improvement or deterioration:

*Just listening to what's going on and what progress Mum's doing. That's the main thing and that she's not going backwards that she's going forwards...*

Further to understanding patient's condition, family members also wanted to become aware of the nursing treatments, interventions and plans for nursing care that were provided, which was related to the subtheme labelled understanding patient treatment:

*I think it is a worthwhile exercise in terms of knowing what's being done to the patient who is usually a relative of yours and understanding what the treatment is.*

### **Interacting with nursing staff**

The theme interacting with nursing staff included five subthemes revolving around interactions between family members and nursing staff in the handover process. The first subtheme, sharing information, identified family members' ability to provide relevant details about the patient of which nurses were sometimes not aware, thereby enhancing the quality of information communicated:

One family member was observed being able to share information about what a splint was being used for and the occupational therapist's latest orders regarding the splint. The following quote refers to Michelle helping with the "support" or splint:

*They're the professionals and Steve and I both rely on them and I mean the only thing I could help them with was in regard to the support that was the latest that I had heard of.*

As reflected in the second subtheme, clarifying information, family members were able to identify information the nurses handed over that was missed or wrong, therefore, improving the quality of handover:

*...or give them information like I think they had the wrong information there about my Mum's incontinence, she isn't incontinent so much...she just gets a bad cough.*

Another subtheme that emerged was assisting with care. Family members spoke of helping with various duties during hospitalization. Such 'hands-on' assistance provided another source of information, which they discussed with nursing staff during the handover. Assisting with care also provided an opportunity to clarify information with the nurses:

*I help do Mum's washes and changes and that's not common with every other family member...we hand it on to their RNs what we find, a scratch or a breakdown, so that's my role there, I think it's just that I'm available to answer as many questions of what they want to know.*

The next subtheme, asking questions, showed that all family members shared the same opinion, that they felt not only comfortable but confident to voice questions during the handover. Family members were able to gain additional information by questioning the nurses:

*...I feel free to ask questions if I wanted to.*

The final subtheme encapsulates the role of the family member as an interpreter for the patient. Due to the patients being ill, vulnerable or hearing impaired, the family members usually took on the patient's role of listening and participating with the nurses in the handover and would then explain elements of the handover to the patient in lay terms so the patient was informed:

*...he can't hear properly so then I can communicate to him anything that he needs to know to keep an honest and open communication with him about things that are happening, so that's good for him.*

### **Finding value**

The theme finding value included five subthemes, indicating how and why they valued the information gained during handover. The first subtheme, feeling at ease, arose as the family members gained a clear perspective of the patient's condition and treatment during handover and were able to feel confident, which relieved family members' distress:

*Eases your mind a bit doesn't it, coz I could be thinking all kinds of wild things and then you listen to them talking and it brings is back into perspective a bit.*

Another feeling evoked by family members was feeling included, which was the second subtheme. They felt encouraged to be part of the handover and were seen as an integral component of the larger whole:

*It's fantastic, because of the fact that I can be involved in the handover.*

In addition to feeling at ease and feeling included, the subtheme of valuing individualization of patient care emerged. Family members commented positively on the way patients were treated during handover. The patients were no longer just a bed number; the handover enabled the nurses to humanise the patients and tailor their care to individual needs:

*Doing it (handover) at the front desk they just know a number of the bed they don't know the name of the person you're talking about. I think doing it at the bed the nurse can talk to Mum, tell her what happened through the day...*

Another subtheme, preparing for the future, revolved around having the ability to prepare for discharge, through being kept up-to-date on the patient's condition and treatment, and expectations for the period following discharge:

*Well you have a role as a bystander, you're not the patient, you're not providing the nursing but ultimately you are going to be involved in discharge so it's good to know what's going on.*

The final subtheme, maintaining patient privacy, revealed that family members felt that any lack of privacy created by bedside handover was outweighed by the benefits of improving the accuracy of communication:

*The only thing, coz there is three other beds in the room, you know somebody else could be listening in, but I think people are too concerned with their own care to really notice what's going on, and it's nothing extremely confidential, it's just the medication the person's on, it's not discussing anything that the person should be embarrassed about. You'll be sitting there having a conversation about bowel movements (Laughs)... but no couldn't think of anything that they said that should be excluded.*

## **DISCUSSION**

This study identified a number of perceived benefits of family members' involvement in bedside handover. The findings are congruent with the four core concepts of FCC.

The first FCC concept of dignity and respect is evident in the study (Institute for Family-Centred Care 2008). Bedside handover demonstrated to family members that nurses were individualising the patient's care rather than treating people indifferently; reinforcing the model of FCC. McMurray et al. (2011) found that patients also felt respected and acknowledged during bedside handover, whereby nurses made patients feel like a person rather than just a patient. The process of bedside handover allows the nurses to become closer both in physical and social proximity to the patient and family, creating a different dynamic to other depersonalised methods of handover.

The family also appreciated the opportunity to listen to the handover and interact as partners with nursing staff, which suggested to them that nurses respected them. This is a positive finding given that other studies have found a lack of interaction between nurses and

family members (Benzein *et al.* 2008). Perhaps bedside handover is a way to redress this lack of support by aiding nurses' ability to make family members feel included.

Maintaining confidentiality is another form of respect. It was notable that families did not voice concerns regarding patient privacy at the bedside. This is similar to earlier studies of patients' perspectives, where patients also reported no issues with privacy during bedside handover (Cahill 1998, Greaves 1999, Kassean & Jagoo 2005, McMurray *et al.* 2011). The findings of previous studies indicate that concerns regarding patient privacy are more of a problem for nurses (Greaves 1999, Currie 2002, O'Connell *et al.* 2008, Chaboyer *et al.* 2009) than patients (McMurray *et al.* 2011) and family members.

Information sharing, a second concept of FCC (Institute for Family-Centred Care 2008), was a crucial element in family members' participation, in fact, bedside handover exemplified what is meant by a two-way process of information sharing. The family members thought that the bedside handover helped them to be better informed by nurses about aspects of the patients' conditions such as diagnosis and treatments, especially when they were encouraged to ask questions. These findings consonant with studies that have outlined the importance for family members of being informed about patients' condition (Astedt-Kurki *et al.* 1997, Astedt-Kurki *et al.* 2001a, Astedt-Kurki *et al.* 2001b, Jumisko *et al.* 2007 Duhamel *et al.* 2009) and treatment (Astedt-Kurki *et al.* 1997, Astedt-Kurki *et al.* 2001b, Duhamel *et al.* 2009). Having the opportunity to ask nurses questions is congruent with prior studies that show that bedside handover had the ability to address patients' questions (Timonen & Sihvonen 2000, Kassean & Jagoo 2005).

Family members were able to inform nursing staff about pertinent patient information, illustrating a true relationship of reciprocity, a core assumption of the nurse-family relationship (Leahey & Harper-Jaques 1996). Interestingly, from a nursing perspective, the

mutual provision of information is instrumental to improving nursing care (Burton 2000, Astedt-Kurki *et al.* 2001b). Conversely, in May *et al.*'s (2001) study, family members were not overly comfortable with providing information to nurses. Perhaps bedside handover allowed family members to feel comfortable enough to share their knowledge and promote two-way communication.

Family members spoke of their ability to clarify the information nurses handed over at the bedside. Two studies on patients' perspectives yielded similar results, whereby patients monitored information handed over at the bedside and clarified inaccuracies (Cahill 1998, McMurray *et al.* 2011). With the high number of handover content errors (Currie 2002, Sexton *et al.* 2004, Fenton 2006, O'Connell *et al.* 2008, Staggers & Jennings 2009, Riesenber *et al.* 2010, Welsh *et al.* 2010), bedside handover gives the family member an opportunity to monitor the accuracy of information, which may improve the quality of information handed over and ultimately promote safer care.

Being involved in handover was time efficient in that it helped family members access information while they were visiting. Family members commonly have to chase nurses and initiate conversations to find out information on the ward (Astedt-Kurki *et al.* 1997, Astedt-Kurki *et al.* 2001a, Astedt-Kurki *et al.* 2001b, May *et al.* 2001). Instead, bedside handover offers an easy and predictable mode of communication, with a formal time for interactions being embedded into nurses' work processes, allowing families to plan their visits. In this respect, bedside handover challenges the traditional methods of communication, whereby nurses and doctors are authoritative, holding information on patients (MacKean *et al.* 2005, Sodomka 2006).

The third FCC concept is participation (Institute for Family-Centred Care 2008). Bedside handover gave the families an easy way to participate in the patient's care. Studies

conducted in other settings have reported patients' lack of involvement in bedside handover for various reasons (Cahill 1998, Greaves 1999, Timonen & Sihvonen 2000, McMurray *et al.* 2011). The participants in this study also commented on patients' limited ability to participate, but with family members taking an active role in the bedside handover, they were able to act on behalf of the patient. This type of participation has been identified as a common duty in some families (Jumisko *et al.* 2007, Austin *et al.* 2009). Their active participation also helped them convey information to the patient, a benefit reported in other studies (Bergbom & Askwall 2000, Söderströma *et al.* 2009). Providing information and ensuring the patients' needs are met, promotes patients' autonomy and independence, which is important to both family members and patients (Phinney 2006, Cahill *et al.* 2009). This is particularly relevant in the current era of patient centred care, where being focused on the patient rather than the provider is seen as an indication of quality (Luxford *et al.* 2011).

Being treated as a contributor to care helped the family members feel that they were doing all they could for the patient. Other studies have highlighted family members' desire to assist in patient care while in hospital (Astedt-Kurki *et al.* 1997, Astedt-Kurki *et al.* 1999, Shields 2001, Shields *et al.* 2006). Family members who were already carers for the patient would be familiar with assisting the patient (Shields 2001, Jolley & Shields 2009), and assisting in care might help promote the normality of patient and family life (Saveman 2010). On the other hand, helping with some care may ease the family into the caring process, which may be new to them. The family members may feel they are helping the nurses through assisting in care, which may make them feel like a participant in the hospital setting, ultimately empowering the family through active engagement (MacKean *et al.* 2005, Bamm & Rosenbaum 2008, Kaufman 2008, Polst & Nelson 2008).



A fourth dimension of FCC is collaboration (Institute for Family-Centred Care 2008). By the family and nurse undertaking a collaborative relationship, they were able to work together to prepare for the future. Discharge information was an important topic for family members to discuss with nurses, which was similar to the findings of other studies (Astedt-Kurki *et al.* 2001a, Astedt-Kurki *et al.* 2001b). Importantly, lack of discharge information has been associated with family dissatisfaction (Almborg *et al.* 2009). Discharge planning is an extremely important part of the hospital experience. Bedside handover provided a source of information to assist family members in planning patient care at home. This resonates with the findings of Chaboyer *et al.* (2008) where nurses agreed that discharge planning was improved after implementation of bedside handover.

### **Limitations**

The current study is limited in being confined to a single site, in one rehabilitation ward, at a medium-sized hospital with a sample that included only women. However no claims for generaliseability are made from interpretive studies, and all care was taken to separate out preconceptions from interpretations. The small sample size also precluded a demographic analysis of differences, which would have been instructive in a larger sample. However, the findings provide insight into family members' perspectives, which could lead to further research studies and expansion of this type of family-centred research.

### **CONCLUSION**

This study demonstrates that bedside handover was one strategy to promote FCC, an approach to care that is now known to improve both quality and safety in health care. It follows that because nurses are exposed to family members frequently and are available 24 hours a day, they should take advantage of this unique opportunity (Wright & Bell 2004). By involving family members in bedside handover, a truly collaborative relationship can occur

between the family and the nurses, which could lead to increased satisfaction by both parties. While FCC appears to be a difficult concept to effectively implement (Jolley & Shields 2009, Duhamel 2010), bedside handover may be one way to begin a FCC approach to nursing practice. Families value the opportunity to participate in bedside handover and this group believed they can improve its accuracy.

## **RELEVANCE TO CLINICAL PRACTICE**

The findings of this study suggest a number of recommendations for nursing practice, management, education and future research. First, implementation of bedside handover in other ward settings should be encouraged to promote a FCC approach to nursing, improving the quality and accuracy of information and increase patient safety. Second, because bedside handover reflects FCC and was valued by families, adult hospital wards should create an environment that fosters FCC. Finally, initiatives should be undertaken that promote family participation in bedside handover. Family members want to be involved, and nurses need to look at the family as a partner that enhances patient care.

For managers, firstly, support will be required to implement bedside handover and this may be expedited by using standard operating procedures. Nurses and family members need to be able to voice concerns to the manager about bedside handover and work through these accordingly. Second, it will be important to evaluate the new process in order to assess its improvement in the local context. Third, managers should aim to foster an environment that supports families, adding FCC values into the ward's ethos and making this approach clear to staff.

In regards to education, some nurses may require more knowledge about the benefits of FCC and how it can best be implemented; this may encourage nurses to include family members in bedside handover. Second, some nurses may need additional education and training in communication skills; this will equip them with language that encourages family

members to participate in bedside handover and enable them to be in an effective and interactive relationship with family members.

Finally, the study findings suggest that this line of research should be extended to identify whether there are any gender related differences in family members' perspectives of bedside handover. Second, the family members who participated tended to be close and involved in the ongoing care of the patient. It could be that studies in different settings, with different types of clients and family members, could have alternative findings. Third, there should be ongoing research into ways to foster FCC in adult hospital settings. Finally, further research should be conducted on effective ways for nurses to communicate and work effectively with family members (Flowers *et al.* 2008).

## REFERENCES

- Australian Commission on Safety and Quality in Health Care (ACSQHC) (2007) Priority program 5: National clinical handover initiative: Industry brief. Retrieved January 9, 2010, from [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/2AF6AC7C1D157D1CA2572DF00083B3D/\\$File/Industry%20Briefing%20Clinical%20Handover.PDF](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/2AF6AC7C1D157D1CA2572DF00083B3D/$File/Industry%20Briefing%20Clinical%20Handover.PDF)
- ACSQHC (2008) Windows into safety and quality in health care 2008. Retrieved February 13, 2009, from [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/4FCB4F459D87F262CA2574EF0071099C/\\$File/Media%20release%20-%20National%20Report%20Launch.pdf](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/4FCB4F459D87F262CA2574EF0071099C/$File/Media%20release%20-%20National%20Report%20Launch.pdf)
- Almborg A, Ulander K, Thulin A & Berg S (2009) Understanding the needs of families: Discharge planning of stroke patients: The relatives' perceptions of participation. *Journal of Clinical Nursing* **18**, 199-209.
- Astedt-Kurki P (2010) Family nursing research for practice: The Finnish perspective. *Journal of Family Nursing* **16**, 256-268.
- Astedt-Kurki P, Lehti K, Paunonen M & Paavilainen E (1999) Family member as a hospital patient: Sentiments and functioning of the family. *International Journal of Nursing Practice* **5**, 155-163.
- Astedt-Kurki P, Paavilainen E, Tammentie T & Paunonen M (2001a) Interaction between family members and health care providers in an acute care setting in Finland. *Journal of Family Nursing* **7**, 371-390.
- Astedt-Kurki P, Paavilainen E, Tammentie T & Paunonen M (2001b) Interaction between adult patients' family members and nursing staff on a hospital ward. *Scandinavian Journal of Caring Sciences* **15**, 142-150.
- Astedt-Kurki P, Paunonen M & Lehti K (1997) Family members' experiences of their role in a hospital: A pilot study. *Journal of Advanced Nursing* **25**, 908-914.
- Austin W, Goble E, Strang V, Mitchell A, Thompson E, Lantz H, Balt L, Lernermeier G & Vass K (2009) Supporting relationships between family and staff in continuing care settings. *Journal of Family Nursing* **15**, 360-383.
- Bamm EL & Rosenbaum P (2008) Family-centered theory: Origins, development, barriers, and supports to implementation in rehabilitation medicine. *Archives of Physical Medicine and Rehabilitation* **89**, 1618-1624.
- Benzein EG, Johansson P, Årestedt KF & Saveman B (2008) Nurses' attitudes about the importance of families in nursing care: A survey of Swedish nurses. *Journal of Family Nursing* **14**, 162-180.
- Bergbom I & Askwall A (2000) The nearest and dearest: A lifeline for ICU patients. *Intensive and Critical Care Nursing* **16**, 384-395.
- Burton CR (2000) A description of the nursing role in stroke rehabilitation. *Journal of Advanced Nursing* **32**, 174-181.

- Cahill E, Lewis LM, Barg FK & Bogner HR (2009) "You don't want to burden them": Older adults' views on family involvement in care. *Journal of Family Nursing* **15**, 295-317.
- Cahill J (1998) Patient's perceptions of bedside handovers. *Journal of Clinical Nursing* **7**, 351-359.
- Chaboyer W, McMurray A, Johnson J, Hardy L, Wallis M & Chu FY (2009) Bedside handover: Quality improvement strategy to "Transform care at the bedside". *Journal of Nursing Care Quality* **24**, 136-142.
- Chaboyer W, McMurray A, Wallis M & Chang HA (2008) Standard operating protocol for implementing bedside handover in nursing. Retrieved August 24, 2010, from [http://www.health.gov.au/internet/safety/publishing.nsf/content/com-pubs\\_CH-BH&WC-con/\\$File/SOP-Bedside-Handover.pdf](http://www.health.gov.au/internet/safety/publishing.nsf/content/com-pubs_CH-BH&WC-con/$File/SOP-Bedside-Handover.pdf)
- Clancy CM (2008) The importance of simulation: Preventing hand-off mistakes. *Association of Operating Room Nurses* **88**, 625-627.
- Currie J (2002) Improving the efficiency of patient handover. *Emergency Nursing* **10**, 24-27.
- Duhamel F (2010) Implementing family nursing: How do we translate knowledge into clinical practice? Part II: The evolution of 20 years of teaching, research, and practice to a center of excellence in family nursing. *Journal of Family Nursing* **16**, 8-25.
- Duhamel F, Dupuis F & Wright L (2009) Families' and nurses' responses to the "One question question": Reflections for clinical practice, education, and research in family nursing. *Journal of Family Nursing* **15**, 461-485.
- Fenton W (2006) Developing a guide to improve the quality of nurses' handover. *Nursing Older People* **18**, 32-37.
- Fisher C, Lindhorst H, Matthews T, Munroe DJ, Paulin D & Scott D (2008) Nursing staff attitudes and behaviours regarding family presence in the hospital setting. *Journal of Advanced Nursing* **64**, 615-624.
- Flowers KA, St John W & Bell JM (2008) The role of the clinical laboratory in teaching and learning family nursing skills. *Journal of Family Nursing* **14**, 242-267.
- Gangeness GE & Yurkovich E (2006) Revisiting case study as a nursing research design. *Nurse Researcher* **13**, 7-13.
- Greaves C (1999) Patients' perceptions of bedside handover. *Nursing Standard* **14**, 32-35.
- Holloway I & Wheeler S (2002) *Qualitative research in nursing* (2nd ed.). Blackwell Publishing, Carlton, Victoria.
- Institute for Family-Centred Care (2008) Advancing the practice of patient and family centred care: How to get started. Retrieved February 22, 2010, from [www.familycentredcare.org](http://www.familycentredcare.org)
- Institute for Patient- and Family-Centred Care (2010) FAQ. Retrieved October 20, 2010, from <http://www.ipfcc.org/faq.html>
- Jolley J & Shields L (2009) The evolution of family-centered care. *Journal of Pediatric Nursing* **24**, 164-170.
- Jumisko E, Lexell J & Söderberg S (2007) Living with moderate or severe traumatic brain injury: The meaning of family members' experiences. *Journal of Family Nursing* **13**, 353-369.

- Kassean HK & Jagoo ZB (2005) Managing change in the nursing handover from traditional to bedside handover: A case study from Mauritius. *BioMed Central Nursing* **4**, 1-6.
- Kaufman J (2008) Patients as partners. *Nursing Management* **39**, 45-48.
- Kelly M (2005) Change from an office-based to a walk-around handover system. *Nursing Times* **101**, 34-35.
- Leahey M & Harper-Jaques S (1996) Family-nurse relationships: Core assumptions and clinical implications. *Journal of Family Nursing* **2**, 133-151.
- Leonard M, Graham S & Bonacum D (2004) The human factor: The critical importance of effective teamwork and communication in providing safe care. *Quality and Safety in Health Care* **13**, 85-90.
- Luck L, Jackson D & Usher K (2006) Case study: A bridge across the paradigms. *Nursing Inquiry* **13**, 103-109.
- Luxford K, Gelb Safran D & Delbanco T (2011) Promoting patient-centred care: A qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. *International Journal for Quality in Health Care* **23**, 510-515.
- MacKean GL, Thurston WE & Scott CM (2005) Bridging the divide between families and health professionals' perspectives on family-centred care. *Health Expectations* **8**, 74-85.
- May J, Ellis-Hill C & Payne S (2001) Gatekeeping and legitimization: How informal carer's relationship with health care workers is revealed in their everyday interactions. *Journal of Advanced Nursing* **36**, 364-375.
- McMurray A, Chaboyer W, Wallis M, Johnson J & Gehrke T (2011) Patients' perspectives of bedside nursing handover. *Collegian* **18**, 19-26.
- Nelson AM (2008) Addressing the threat of evidence-based practice to qualitative inquiry through increasing attention to quality: A discussion paper. *International Journal of Nursing Studies* **45**, 316-322.
- O'Connell B, Macdonald K & Kelly C (2008) Nursing handover: It's time for a change. *Contemporary Nurse* **30**, 2-11.
- Phinney A (2006) Family strategies for supporting involvement in meaningful activity by persons with dementia. *Journal of Family Nursing* **12**, 80-101.
- Polst G & Nelson DP (2008) An interdisciplinary team approach to evidence-based improvement in family-centered care. *Critical Care Nursing Quarterly* **31**, 110-118.
- Riesenberg LA, Leisch J & Cunningham JM (2010) Nursing handoffs: A systematic review of the literature. *The American Journal of Nursing* **110**, 24-34.
- Saveman B (2010) Family nursing research for practice: The Swedish perspective. *Journal of Family Nursing* **16**, 8-25.
- Saveman B, Mahlen CD & Benzein EG (2005) Nursing students' beliefs about families in nursing care. *Nurse Education Today* **25**, 480-486.
- Sexton A, Chan C, Elliott M, Stuart J, Jayasuriya R & Crookes P (2004) Nursing handovers: Do we really need them? *Journal of Nursing Management* **12**, 37-42.
- Shields L (2001) A review of the literature from developed and developing countries relating to the effects of hospitalization on children and parents. *International Nursing Review* **48**, 29-31.

- Shields L, Pratt J & Hunter J (2006) Family centred care: A review of qualitative studies. *Journal of Clinical Nursing* **15**, 1317-1323.
- Söderströma IK, Saveman B, Hagberga MS & Benzein EG (2009) Family adaptation in relation to a family member's stay in ICU. *Intensive and Critical Care Nursing* **25**, 250-257.
- Sodomka P (2006) Engaging patients and families: A high leverage tool for health care leaders. *Hospitals and Health Networks* **80**, 28-29.
- Staggers N & Jennings BM (2009) The content and context of change of shift report on medical and surgical units. *The Journal of Nursing Administration* **39**, 393-341.
- Taylor B, Kermode S & Roberts K (2006) *Research in nursing and health care: Evidence for practice* (3rd ed.). Thomson, South Melbourne, Victoria.
- The Joint Commission (2005) Sentinel event statistics-June 30, 2005. Retrieved 26 March, 2009, from <http://www.jointcommission.org/SentinelEvents/Statistics/>
- Timonen L & Sihvonen M (2000) Patient participation in bedside reporting on surgical wards. *Journal of Clinical Nursing* **9**, 542-548.
- Van Horn ER & Kautz DD (2007) Promotion of family integrity in the acute care setting: A review of the literature. *Dimensions of Critical Care Nursing* **26**, 101-107.
- Welsh CA, Flanagan ME & Ebright P (2010) Barriers and facilitators to nursing handoffs: Recommendations for redesign. *Nursing Outlook* **58**, 148-154.
- Wright LM & Bell JM (2004) Retrospective: Nurses, families, and illness: A new combination. *Journal of Family Nursing* **10**, 3-11
- Yin RK (2009) *Case study research: Designs and methods* (4th ed.). Sage, Thousand Oaks, CA.

## TABLES AND FIGURES

**Table 1: Family members' perspectives of bedside handover**

Theme	Subtheme
Understanding the Situation	<ul style="list-style-type: none"> <li>Feeling informed</li> <li>Understanding patient's condition</li> <li>Understanding patient's treatment</li> </ul>
Interacting with Nursing Staff	<ul style="list-style-type: none"> <li>Sharing information</li> <li>Clarifying information</li> <li>Assisting with care</li> <li>Asking questions</li> <li>Interpreting for the patient</li> </ul>
Finding Value	<ul style="list-style-type: none"> <li>Feeling at ease</li> <li>Feeling included</li> <li>Valuing individualization</li> <li>Preparing for the future</li> <li>Maintaining patient privacy</li> </ul>