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The art of oral handovers: A participant observational study by undergraduate students in a hospital setting

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Aims and objectives: To explore the conditions for oral handovers between shifts in a hospital setting, and how these impact patient safety and quality of care.

Background: Oral handovers transfer patient information and nursing responsibilities between shifts. Short written summaries of patients can complement an oral handover. How to find the balance between a standardised protocol for handovers and tailoring variations to specific patients and situations is debated in the literature. Oral handovers provide time for discussion, debriefing and problem solving, which can lead to increased team cohesiveness.

Design: This study used a participant observation design.

Method: Fifty-two undergraduate nursing students conducted 1100 hr of participant observation in seven different units in a hospital in Western Norway from 2014–2015. Field notes were analysed using qualitative content analysis.

Results: Six themes emerged from the data: (i) content and structure of the handover, (ii) awareness of nurses' attitudes during oral handover, (iii) verbal and nonverbal communication, (iv) distractions, (v) relaying key information accurately, (vi) ensuring quality through oral handovers.

Conclusion: Developing a familiar structure for oral handovers and minimising the use of abbreviations and unfamiliar medical terms promote clarity and understanding. Limiting disturbances during handovers helps nurses focus on the content of the report. Awareness of one's attitudes and the use of verbal and nonverbal communication can enhance the quality of a handover. Time allocated for an oral handover should allow for professional discussions and student supervision. Involving nurse leaders in promoting the quality of oral handovers can impact the quality of care.

Clinical implications: Oral handovers serve many purposes, such as the safe transfer of patient information between shifts and staff education and debriefing, which enhance team cohesiveness.

KEYWORDS
handoffs, hospital, nursing, nursing handover, nursing students, participant observation, patient safety

1 | INTRODUCTION

Reporting on patients between shifts is a process, known as clinical handover, in which patient information is transferred from one caregiver to another to ensure continuity and patient safety (Mayor, Bangerter, & Aribot, 2012; Riesenberg, Leitzsch, & Little, 2009). Handovers aim to provide accurate and updated information about each patient's treatment, current situation and significant changes. The transferring of responsibility and accountability for clinical care is also important during clinical handovers (Anderson, Malone, Shanahan, & Manning, 2015). An incomplete and poor handover can be dangerous for the patients' safety (Mayor et al., 2012; Street et al., 2011). Thus, an oral handover is risky in the care process because information can be inaccurate, lost, distorted or misinterpreted (Drach-Zahavy & Hadid, 2015; Holly & Poletick, 2014).

According to Bakon, Wirihana, Christensen, and Craft (2017), four different styles of handover are used in clinical practice: verbal bedside handover, tape-recorded handover, verbal handover and written handover. This article focuses on verbal or oral handovers between shifts, carried out in the nursing station and not by the bedside, normally called a handover, handoff, sign out, intershift report or, simply, report (Johnson et al., 2014; Staggers & Blaz, 2013; Street et al., 2011). During oral handovers, the healthcare workers who are at the start of their shift receive a report from one of the team members who is ending a shift. Mayor et al. (2012) noted that the outgoing nurses need to summarise many pieces of information and provide oncoming nurses with a global judgement of each patient's situation. Patients are not involved in oral handovers between shifts; moreover, because the communication occurs away from patients, it can be challenging for the oncoming team to associate the information with the right patient (Street et al., 2011). However, oral handovers ensure patient confidentiality, and they provide nurses with the opportunity to transfer responsibility and accountability for patients and nursing tasks to the oncoming team (Bakon et al., 2017).

Street et al. (2011) found that the majority of nurses in their study preferred to receive a combination of verbal and written information during handovers because they found it difficult to follow an oral handover, even though the information was satisfactory. In the literature, some studies discuss the advantages of using a short, written summary of patients to complement the oral handover (Bakon et al., 2017; Johnson, Jefferies, & Nicholls, 2012; Poletick & Holly, 2010). It is recommended that nurses use standardised information, such as the Nursing Handover Minimum Data Set (NH-MDS), with generic data items (identification of patient, clinical history, clinical status, care plan and outcomes of care, clinical risks/alerts, estimated date for discharge) (Johnson et al., 2012). The NH-MDS can provide a comprehensive account of a patient's condition and care in a prewritten summary; thus, it can improve patient safety by reducing confusion and preventing gaps in patient information. In this way, it can complement an oral handover.

There is debate over how to strike a balance between standardisation and variations tailored to specific hospital units and patients to reduce subjectivity and redundant information. Mayor et al. (2012) claimed that there is no evidence that standardisation results in a more efficient handover; instead, scholars recommend verbal and interactive handovers. According to Drach-Zahavy and Hadid (2015), studies of standardised handover protocols have not yet provided evidence that they have distinct advantages over tailored protocols. However, some studies have reported that the quality of an oral handover can be improved by using a standard protocol, adapted to local settings or checklists, with mnemonics and minimum data sets, listed in a specific order (Drach-Zahavy & Hadid, 2015; Street et al., 2011). Bakon et al. (2017) reviewed various models that might optimise nursing handovers. They did not find that one was superior to others. Rather, they argued that a minimum data set with a familiar structure should be covered in an oral handover that can increase the reliability and standardisation of information, which can promote situational awareness and patient safety. This is also supported by Staggers and Blaz (2013), who argued that the structure of a handoff should be tailored to a unit's nurses and their contextual needs. Communication between the outgoing and oncoming team can provide new perspectives on patient situations; this can help nurses detect and correct errors. Face-to-face verbal updates provide nurses with the ability to ask questions and discuss topics around patient care; this process is significantly linked to fewer treatment errors (Drach-Zahavy & Hadid, 2015). In the literature, communication and working environment are mentioned as important for the quality of handovers; however, little is written about contextual factors that impact patient information transfer.

In addition to transferring patient information, oral reports also allow teams to discuss resource management, solve problems and improve collaboration. It is also reported that handovers can develop team cohesiveness and provide an opportunity for debriefing (Kitson, Muntlin Athlin, Elliott, & Cant, 2014; Mayor et al., 2012).

The location and time for a handover are less often discussed in the literature. Handovers conducted at the nursing station or in a designated handover room ensure the confidentiality of the information that is shared and discussed (Street et al., 2011). The amount of time set aside for an oral handover also impacts the quality. Street

What does this paper contribute to the wider global clinical community?

- Reinforces that nonverbal communication, such as tone of voice, body language and attitudes, affects communication during handovers.
- Emphasises that suitable rooms should be used during handovers to minimise distractions and safeguard information transfer.
- Reinforces that team spirit is built by allowing for education, debriefing, discussions and clear distribution of responsibility during a handover.

et al. (2011) found that a longer handover was associated with poorer information transfer; however, if the handover is too brief, important information might be left out. Holly and Poletick (2014) found that, often, reports were a hurried experience, occurring wherever there was a place to have them. Inability to access accurate patient information, interruptions and idle chatting during a handover, as well as poor balancing of time, have been reported to hamper the quality of a handover (Street et al., 2011).

In the literature about oral handover, the main focus is on the content of the handover. Less has been studied about conditions and how the handover is carried out. To increase the knowledge base around elements of an appropriate handover between shifts in hospital settings, we carried out a participant observational study. The research question for the study was as follows: How are conditions and content of oral handover in hospital settings related to quality of care.

2 | METHOD

2.1 | Study design

The research project aimed to explore conditions and content of oral handovers in a hospital setting and how they are related to the quality of patient care. Participant observation was chosen as the best design to provide insights into the conditions and content of handovers between shifts. Participant observation builds on the ethnographic method, aiming to develop knowledge with an insider's perspective (Mulhall, 2003; Newell & Burnard, 2006; Polit & Beck, 2012).

2.2 | Study settings and participants

The research project was developed in collaboration with a university college and a small hospital in Western Norway. Second-year nursing students in a bachelor's programme participated in the research project as an alternative 3 weeks of clinical practice at the end of their second year. The research project was carried out in the following hospital wards: an intensive care unit (ICU), medical wards (general medicine, heart/lung, stroke and geriatric unit) and surgical wards (orthopaedic and soft tissue). Prior to the project, students had no lectures in class about oral handover. However, most of them had tried to conduct an oral report at the end of their 8 weeks of clinical practice in nursing homes in their first year. In their second year, one of the learning outcomes was that students towards the end of the year should master, to a certain degree, being the group leader of six to eight patients and conducting oral handovers between shifts. The second cohort in 2014 and 2015 had experience of being group leaders before the project started.

To limit the workload for the wards, and to ease the new role of the nursing students as researchers in the hospital, the following inclusion criteria were applied: a maximum of two students should be assigned to each unit and, if possible, the students should return to the same unit where they had worked earlier in their clinical practice.

The project lasted for 2 years, and four cohorts of students participated. In spring 2014, a cohort of 12 and a cohort of 15 students who met the inclusion criteria were chosen by teachers to participate in the study. In spring 2015, a cohort of 13 and another cohort of 12 students who met the inclusion criteria volunteered to participate in the study. A total of 52 students participated in this study.

2.3 | Data collection

The nurses in the hospital and nursing teachers collaboratively developed a form to guide and structure the nursing students' observations before the research project began (Table 1). In this hospital, the nurses use "Twelve Areas of Function" (see Table 2) as a familiar framework, as these 12 areas are built into the electronic documentation system they use. It also works as a system for nurses to organise patient information in the oral handover related to the patients' clinical status.

TABLE 1 Observational form used for oral handovers in hospital units

1. When you are assigned a patient
   a. To what degree do you evaluate the handover to be sufficient for you to take on the nursing responsibility for the patient?
2. Observations in caring situations and other kinds of collaboration with the patient
   a. What factors related to treatment and care are especially important to address in a handover?
   b. What factors do you see as being particularly important for patient safety?
   c. Is there something you have become especially aware of that seems important for the patient's experience of being a patient?
3. Ongoing informal handovers
   a. How does the handover match what you emphasise as being important based on your observations and interactions with the patient?
   b. How is the patient's holistic situation conveyed in the handover?
   c. Is unnecessary information conveyed during handover? If so, what and how?
4. When you follow the patient over several days, or from one unit to another
   a. Based on your professional judgement, to what extent does the handover provide a holistic view of the patient's situation and need for nursing care?
5. Other conditions related to a handover
   a. Does the supervision of students, nurses or other healthcare personnel occur?
   b. Do discussions related to professional evaluations of procedures and other treatment-related initiatives occur?
   c. How does a handover safeguard the interactions in and cohesion of the caring group?
   d. Is the distribution of responsibilities clarified?
   e. Do team members take care of each other in terms of how to manage special patient challenges?
   f. Are there other issues you want to highlight as being important in a handover?

TABLE 2 Twelve areas of function

1. Communication/senses
2. Knowledge/development/mental status
3. Repertory/circulatory system
4. Nutrition/liquid/electrolyte balance
5. Elimination
6. Skin/tissue/wound
7. Activity/functional status
8. Pain/sleep/rest/wellness
9. Sexuality/Reproduction
10. Social history/planning of discharge
11. Spiritual/cultural/lifestyle
12. Other/physician delegated activities and observations

During the first week of the project, the students received instructions and training to prepare them to carry out the unfamiliar participant observation role during oral handovers. The lectures covered research ethics and the research process of participant observation including data collection, how to analyse data and write a research report. We also reflected together on their experiences of and thoughts about oral handover to make them aware of their pre-understanding of oral handovers before the study started. We worked through Tables 1 and 2 with them so that the students should have a common framework for their observation. We used role playing, where the students practised writing down observations and reflection, and we discussed how to obtain good quality data and how to distinguish between observations and reflections.

The second week, the students took part in 3 days of participant observation. Each student was assigned one main patient to follow over the 3 days. They were also encouraged to pay attention to the bigger picture of patient information exchange both during the oral handover between shifts and as the flow of information occurred during the shift in the ward they were observing. Students began their observation during the afternoon shift on the first day and during the day shifts for the two subsequent days. They were dressed like ordinary students in uniforms, and they participated in some nursing care, as long as it did not prohibit them from observing the flow of information during the handovers. The students in this project did not conduct oral handovers themselves, and they just observed others doing it. The students discreetly wrote detailed observations and reflections on prepared sheets of paper. All four cohorts participated in the study for a total of 156 days; this resulted in a total of 1100 hr of participant observation from one ICU unit, four medical units and three surgical units.

The third author visited the students during the first day of observation to ensure that they understood their role and began to take part in the participant observation. The second and third days, she met with the students for lunch to provide support and to provide them with an opportunity to discuss the challenges they may have been facing. The second author was a student participating in the study.

2.4 | Data analysis

The third week was used for analysis and writing a report on the research project. The first and third authors supervised the students to conduct qualitative content analyses of their data (Newell & Burnard, 2006; Polit & Beck, 2012). The same method was used to analyse data for all four student cohorts.

Each student started by reading through all their written notes to obtain an overview of the data. Each of the students continued to code their handwritten material with as many codes as possible to become aware of the breadth and depth of their data. After finishing the first round of coding, the first and third authors met with each cohort for a short summary of the process thus far. Then, the students who were placed in the same ward shared and compared codes with each other. Again, we met with the student cohorts and summed up the potential themes they saw in their material. Next, we grouped the students into one medical and one surgical cluster, and they continued to compare codes and develop themes. Finally, all the students in a cohort came together and discussed the content of the main themes and how to name them so they fitted the data. This continued until all the students in a cohort were satisfied. After the third student cohort had analysed the data and developed categories, no new information was added to the project by the forth cohort (spring 2015). Each cohort of students wrote a report about the project; two cohorts developed a poster and a presentation of the project for a research day.

The three authors of this article analysed the four written cohort reports and merged all the themes into six main themes that emerged from the content obtained from the entire research project.

2.5 | Ethics

The leaders in the hospital welcomed the study. The head nurses of each ward and the nurses assigned to work with quality improvement were informed about the study, and they took on the responsibility of informing their staff about the project. The first and last authors developed written materials about the project for the head nurses to distribute and for the students to bring to the wards to share with the staff members who were at work during the 3 days they took part in the participant observation. In some of the units, some nurses were not well informed about the project when it started, but none declined to participate. Patients were not informed about the project, and if they asked the students about their role, the students told them that they were participating in an observational study.

We contacted the Norwegian Centre for Research Data to determine if our project was subject to informed consent. Since the participating students did not record any background or personal information about the patients or the nurses, the project was not subject to notification. All students had to fill in the test form for notification, and we discussed with them in detail how to ensure the anonymity and confidentiality of the patients and nurses in their observation and reflection notes by not documenting any personal information neither from patients nor nurses.

3 | FINDINGS

The number of beds in the units that participated in the study varied from 12–32. Each unit was divided into groups of six to eight patients. Each group was assigned a number of nurses and auxiliary nurses at each shift, and one of the nurses was assigned as the group leader for each shift. In the presentation of findings, we use the term "nurses" for all the healthcare professionals, as the majority of them were either registered nurses (RNs) or Bachelor of Science in Nursing (BSN)-prepared nurses. Some also had postgraduate training.

Six main themes emerged from the final analyses of all our data. These themes represent the content and conditions for oral handovers in a hospital setting, and they show how oral handovers can impact the safety and quality of care for patients in a hospital setting.

3.1 | The content and structure of the handovers

At the beginning of each handover, each member of the oncoming team received a short written summary of each patient, including the patient's name, age, diagnosis, treatment, diet, investigations/surgery and care needs. Although the structure of oral handovers varied within the different units, the best structure for the oncoming team was observed when the reporting nurse started with background information about each patient (age, next of kin and home situation) and then moved on to previous and current diseases before summarising relevant information obtained from admission. A helpful ending of the oral handover was when a clear message was provided about what was most significant for each patient for the coming shift. In this way, the handover provided an overview of the patient's situation and prepared the oncoming team for the coming shift. A less desirable structure was observed when the handover was messy, stressful and poorly arranged. When the reporter provided time for questions before moving on to the next patient, it marked a clear transition from one patient to the next. A familiar handover structure provided a better framework for those receiving the information than if the handover was random and arbitrary. In units where there was an accustomed structure, it enabled nurses to process and organise their own understanding of the situation and they more easily could ask questions relating to missing information.

3.2 | Awareness of nurses' attitudes during oral handover

Attitudes towards working in the hospital and outlooks on the patients that the nurses care for could be conveyed through the way in which the reporter spoke during an oral handover. A wide variety of positive examples were reported in the study, including friendliness, humour and giving people positive feedback. How patients were presented also varied: "Now we come to Mr. ticking bomb," "This is the thief," "This is the foreigner" or "She is a nice lady". These ways of presenting patients made a difference, as they conveyed an attitude that might affect how the nursing staff, as a team, experienced and talked about patients. The reporter could set the tone in the room and create a positive or negative atmosphere. Students observed that when a positive tone was set from the beginning, it could stimulate collaboration and build a supportive culture for healthcare workers. By comparing different handovers during the 3 days of the study, students commented that it looked as though the overall attitude during handover in the beginning of the shift could set the stage for how nurses related to each other and handled challenging situations during a shift.

3.3 | Verbal and nonverbal communication

The reporting nurses' communication skills affected the receiving nurses' understanding of what information in the handover was essential. Nonverbal communication, such as eye contact, facial expressions, nodding the head and using fingers to underline words on paper, seemed to increase understanding within the group. How the nurses were seated at the time of the report was also significant. Sitting face-to-face and with the body open confirmed their interest and promoted respect and communication among the team. When the nurse who led the handover turned his or her back towards the group, for example when reading from a computer screen, he or she appeared less available to the oncoming team and they experienced that it is more difficult to hear what was being said.

How the voice was used and the vocabulary that was chosen seemed to affect the relationship between the reporting nurse and the staff, and the relationships among the staff. A sharp voice, cheeky phraseology, an indistinct voice or mumbling, together with little openness to inviting questions, inhibited the exchange of information. However, in this study, the reporting nurse's voice was usually calm, clear and controlled during the oral handovers.

3.4 | Distractions

Distractions could be in the form of interruptions, such as a phone call, healthcare professionals (physicians, physical therapists, laboratory technicians) entering the room to ask questions about patient information or a patient's next of kin knocking on the door. Nurses that came in late for the handover or engaged in a side conversation could also be interruptions. Noise from within the room or outside of the building could be distracting, such as a photocopier, construction activity, patients' alarms or other staff speaking in the same room. Lastly, the oncoming nurses could be inattentive by focusing on their mobiles, getting coffee or picking up papers. Students observed that the likelihood of distractions seems to decrease when the team met in a designated room at a specific time, than when the oral handover occurred in a busy or multiuse room.

In general, students reported that distractions caused attention to diverge from the content in a handover and thus constituted a threat to the team's ability to concentrate on patient information. The reporter could exercise the authority to set boundaries to reduce or eliminate distractions during handovers. Since distractions

stole time, it could be challenging for the reporter to strike a balance between being on time and maintaining a high quality exchange of patient information. Students observed that the reporter could play an important role in helping the team to concentrate on the transfer of patient information during handover. In the midst of all the distractions observed in this study, it seemed as if the nurses had developed a surprisingly strong ability to stay focused and concentrate during oral handovers.

3.5 | Relaying key information accurately

A detailed and accurate oral handover at the beginning of a shift provided a solid foundation for caring for each patient's needs. Nurses needed to consider many factors in order to ensure that the handover was as timely and relevant to the current situation as possible. When nurses had responsibility for fewer patients, such as in the ICU, they covered more of the 12 Areas of Functioning (Table 2) in the handover. However, in this study, we found that there was more focus on the physical aspects of care than on a patient's psychosocial and spiritual needs.

Another factor that affected handovers was how well the oncoming nurses were familiar with the condition and needs of each patient. Many nurses tried to adapt the content of the handover to the level of knowledge and familiarity of those working a particular shift by asking: "Do you know this patient?" When a patient was known in the unit, the handover focused on the recent challenges, and it was tailored towards the staff members that were least familiar with the patient.

Relaying key information promoted quality follow-up nursing care and prevented misunderstandings and negligence. Examples of quality of care in our data were related to meals, mobilisation, follow-up of patients with dementia, changes in medication, receiving new patients into the unit, acting swiftly on patients with pain, following up with patients after they were given information about a serious diagnosis and addressing spiritual and cultural issues with patients. In one case, information related to a patient, who was a Jehovah's Witness that had refused a blood transfusion, was passed on from shift to shift over the 3 days of the study. Maintaining confidentiality could be challenging in a busy ward. The students observed situations where patients' integrity, dignity and autonomy were sometimes protected and sometimes violated.

3.6 | Building cohesion through oral handovers

In this study, we found that oral handovers provided time for clarifications of and discussions about professional matters related to medication, food and fluid intake, procedures, interprofessional collaboration, patient discharge and accurate patient follow-up. Dialogue between team members during handovers provided nurses with the opportunity to share different views and experiences. Supervision of students also took place during handovers when the reporting nurse challenged nursing students to think through specific aspects of care before entering a patient's room.

It was observed that nurses used handovers to process the frustrations they experienced. The team could provide a place for healthy processing of frustrations where one or more members could process difficult experiences, and received support from colleagues. However, there was a fine line between healthy processing of frustrations and having a nurse talk about a patient in negative way as it could make it difficult for the rest of the team to see the human being behind the patient role.

Distribution of the workload and responsibilities among team members was often discussed and agreed upon at the end of a handover. Workload and responsibilities, related to who should lead the group, care for patients in designated rooms and administer medication, were determined by considering the competency levels of the students and the temporary nurses, as well as by identifying the varying levels of tasks and patient care. By clearly distributing responsibility during an oral handover, nurses could build a sense of shared fellowship. In this way, oral handovers helped develop a holistically minded working environment while simultaneously promoting patient safety. At its best, it was observed that an oral handover could create an opportunity for nurses to understand their patients; thus, handovers contribute to the chain of quality patient care and promote an increased sense of teamwork and camaraderie.

4 | DISCUSSION

This study explored the content and conditions of oral handovers by nurses between shifts in a hospital setting. Even though oral handovers have a wide range of functions (Mayor et al., 2012; Poletick & Holly, 2010), two areas stand out as being important for patient care and safety, so our findings will be discussed in relation to that. The first area relates to the content and how effective and safe handovers can reduce errors and promote safe care. The second area relates to how handovers work as a cultivator of skills in the nursing unit (Holly & Poletick, 2014; Poletick & Holly, 2010).

In our study, oral handovers were carried out differently in different units and within the same unit, depending on conditions, such as who the patients were, who the oncoming nurses were and who was presenting the report. Using a familiar oral handover structure gave the oncoming team a better grasp of the situation and made it easier to ask questions. In the literature, different handover models have been proposed to promote patient safety, reduce errors of omission and enhance the reliability of information transfer (Anderson et al., 2015; Drach-Zahavy & Hadid, 2015; Johnson et al., 2012). Instead of looking for one model that can fit all handover situations, it is now argued that the structure of a handover should be tailored to the context of the clinical area and the needs of the staff members and that each unit should agree on which structure works best for the team (Staggers & Blaz, 2013). The reporting nurse is seen as the gatekeeper of the flow of information; it is also recommended that this person provide the oncoming team with a prewritten one-page information sheet that contains accurate patient information (Holly & Poletick, 2014; Poletick & Holly, 2010). The use of medical

terms and abbreviations might be unfamiliar to students, temporary staff and nurses that are new to the unit; thus, it is best to use terms and abbreviations with caution so as to not hamper the safety of patients.

A medical model is often used for nursing handovers (Holly & Poletick, 2014; Mayor et al., 2012), mostly focusing on facts related to the diagnosis and, to a lesser extent, providing a holistic picture of the patient situation (Johnson et al., 2012). Family dynamics and the patients' emotional responses (Holly & Poletick, 2014) are important for nursing care, and these should be a part of a handover to provide the oncoming team with a global view of the situation (Staggers & Blaz, 2013). In our study, greater focus was placed on the physical aspects of patient care rather than social and spiritual aspects. However, diverse aspects of patient situations were presented and discussed during the handovers, which promoted quality nursing care.

When discussing the quality of an oral handover, the literature is most focused on the content of the oral handover and there is less focus on how attitudes and ways of communication influence the information transfer and the culture in the unit. In our study, attitude, nonverbal and verbal communication stood out as important for *how* the handover was conducted. How the tone was set from the beginning of the shift, such as friendliness and openness, and how stress was handled, seemed to affect the team's spirit. The role of the reporter came through as important. How the reporting nurse introduces patients can motivate or demotivate the oncoming team, thus influencing the quality of the nursing care. Stereotypical characteristics of patients can label a person and colour how the team experiences him or her (Holly & Poletick, 2014). Awareness of how body gestures, tone of voice and the use of clear language impact on how the oncoming team receives the oral handover should be given more focus in clinical practice. Verbal and nonverbal communication can express authority and help the oncoming team focus on the content being presented in a handover. The reporter can also play a significant role in reducing distraction within the team, as well as within the room and outside of the room. These aspects of authority should not be overlooked when discussing the quality of a handover (Holly & Poletick, 2014).

The second area we will discuss is how the oral handover can foster norms and codes of conduct in a unit by the way it is carried out. We will look into how information transfer and time provided for sharing, discussion and teaching contributes to team-building in a particular unit. In this way, the handover serves both a psychological and a sociological function. (Holly & Poletick, 2014; Staggers & Blaz, 2013). In our study, we found that the attitude that was conveyed during handover and verbal and nonverbal communication fostered the culture in the unit. An oral handover, where the oncoming team meets face-to-face with the reporting nurse from the outgoing team, provides time for nurses to discuss professional issues, educate their peers, share their experiences and ventilate their frustrations. Allowing time for such activities is important (Street et al., 2011) as team-building activities develop trust among a group and can increase a team's situational awareness, which enhances patient safety and quality of care (Drach-Zahavy & Hadid, 2015). Being able to discuss difficult events, be educated by one's peers and receive emotional support and encouragement facilitates integration and staff cohesion (Holly & Poletick, 2014).

In this study, the mentoring of students was observed during handoffs. In the hospital where this research was conducted, supervision of second-year bachelor's degree nursing students takes place in most units for 30 weeks each year. Supervision was related to caring for patients during the oncoming shift, but it also served to teach students how to become a reporter in a handover, as that is seen as a part of the duties students should perform at the end of their second year. Supervision of nursing students during handover is rarely discussed in the literature, and more attention should be given to cultivating the nursing skills of students, as that is an important part of their education. The oral handover can serve as an important opportunity for students to ask questions and to take part in professional discussions related to challenging patients or ethical dilemmas.

Distribution of the workload and responsibilities among team members was often discussed during handovers in this study. The transfer of responsibility and accountability between shifts is important for patient-centred care and patient safety (Bakon et al., 2017). Anderson et al. (2015) claimed that the transfer of responsibility and accountability for nursing care during a handover is not often addressed in the literature. Distribution of responsibility for nursing care should be a concern of the unit leader. The role of the unit leader was lacking in the data obtained from this observational study, and Kitson et al. (2014) noted that the role of the unit leader is a neglected area of study in relation to nursing handover standards.

5 | LIMITATIONS

Students participating in this study had limited insight into participant observation as a method, and how to conduct research. To ensure the quality of the project, two faculty members with diverse research experience supervised the four student cohorts and provided continuity. The diversity of the wards included in the study and the volume of data (1100 hr of observation) is one of the strengths of this study. That no new aspects of the themes emerged after the third group indicated that the research project reached saturation with a good coverage of what was going on in the hospital units related to oral handovers.

6 | CONCLUSION

Transfer of information from the outgoing to the oncoming team is best safeguarded when the reporter uses a familiar structure tailored to the needs of each unit. Using a clear and distinct language and avoiding abbreviations or unfamiliar medical terms minimise the possibilities of misinterpretations and enhance patient safety. The reporter can also check if the information is received. Disturbances and

interruptions should be limited as much as possible during shift handovers and the reporting nurse can play a significant role in doing so. By reflecting on how words, tone of the voice and body gesture can express attitudes during handovers, a positive atmosphere and quality of the oral handover can increase.

Oral handovers take time. Thus, each unit should strike a balance between handovers that are too short, thereby risking that significant information might be omitted, leading to delays and errors in the follow-up of patients, and handovers that are too long, which could take valuable time away from providing quality patient care. However, allowing time in a handover for professional discussions and the supervision of students and those new to the team is important for the development of professional quality and patient safety.

7 | RELEVANCE FOR CLINICAL PRACTICE

This study explored the conditions for oral handovers between shifts in a hospital using participant observation carried out by second-year nursing students. The findings show a variety of conditions that can improve or hamper the transfer of patient information during oral handovers. Rooms suitable for oral handovers, a minimum of disruption and distraction during a handover between shifts, for oncoming and outgoing nurses as well as the interprofessional team and families, help ensure that the nursing team can concentrate on the information presented during a handover. Each unit cared for different groups of patients, so the pattern of the oral handovers varied in the hospital. However, using a familiar oral handover structure in a ward supported receipt of the information and made it easier for nurses to ask for missing information. The verbal and nonverbal communication in a handover seemed to set the tone for the oncoming team, and its staff and unit leaders should take this into consideration to promote good quality care for all patients.

In addition to transferring patient information from one team to the next, oral handovers provide time for a team to clarify what is unclear and discuss the patients and all nursing-related issues. During handovers, time was also assigned to educate and assist nursing students in understanding what is important for them to pay attention to.

As this article demonstrates, many aspects are served during an oral handover to ensure a high level of patient safety. While situations in units differ, the reporting nurses tried to use oral handovers to prepare the nursing on the oncoming team, and ensure that their skills and abilities match the needs of the patients. Achieving this requires sound professional judgement, and it is an art to do it well.

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CONTRIBUTIONS

Design of the study and ethical approval: TG and KAE; data collection: SNM and KAE; data analysis: SNM, TG and KAE; manuscript preparation, drafting the manuscript and critically editing the manuscript: TG, KAE and SNM; approval of the final manuscript: all three.

CONFLICT OF INTEREST

The authors have declared that there are no conflicts of interest for this study and report.

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