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Patient participation strategies: The nursing bedside handover

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Abstract

Patient participation is an important goal in today's health care and considered necessary to achieve safe and quality patient care. The purpose of this paper is to discuss the historical and theoretical background surrounding the concept of patient participation in health care and specifically to examine patient participation strategies which have been reported to be of influence when employed during the nurse to nurse and patient to nurse activities encompassed in the bedside handover. The bedside handover is the nursing activity of transferring primary nursing responsibility of care from one nurse to another. Encouraging patients to participate during this process facilitates the sharing of information, knowledge, communication, care planning and patient self-care. Empirical studies on patient participation during the nursing bedside handover among inpatient adults were selected from the databases of CINAHL. Criteria for selection included empirical studies published in English and in peer reviewed journals from September 2007 to August 2017. Eight studies published between 2011-2017 are presented in this paper. Most studies ($n = 6$) used qualitative methods. Patients viewed the bedside handover as an opportunity to partner in care, to be informed, to ask questions and correct inaccuracies. Barriers included the use of medical jargon, lack of patient desire to participate, nurses dominating the conversation, and patients feeling ignored. The majority of studies were conducted at single-site settings. Further research is warranted to examine whether the nursing bedside handover leads to improved patient outcomes.

Keywords

Patient experience, patient participation, patient engagement, nursing handover, bedside handover, sharing health information, healthcare, communication

Introduction

Patient participation is a key goal in present day health care,¹⁻³ and considered necessary in order to achieve safe and quality patient care.^{4,5} A concept analysis by Sahlsten, Larsson, Sjoström et al.⁶ defined patient participation as “an established relationship between nurse and patient, the surrendering of some power or control by the nurse, shared information and knowledge, and active engagement together in intellectual and/or physical activities.” Nurse-patient interactions that encourage participation include the sharing of information and knowledge, communication with nurses and health care staff, care planning,⁷ bedside handover,⁸ web-based health related information, patient portals,⁹ and shared decision making.¹⁰ Emerging evidence suggests that patients who actively participate in their care, experience better health outcomes, patient safety,² quality of care,^{4,5} and increased health promotion.¹³ The concept of patient participation is broad and encompasses patients across the age span, various settings, and various components of care. The purpose of this paper is to discuss the historical and theoretical background surrounding the concept of patient participation in health care and specifically to examine patient participation strategies which have been reported to be of influence when employed during the nurse to nurse and patient to nurse activities encompassed in the bedside nursing

handover. The bedside handover is the nursing activity of transferring primary nursing responsibility of care from one nurse to another. Encouraging patients to participate during this process facilitates the sharing of information, knowledge, communication, care planning and patient self-care. Several theoretical approaches with relevance to the concept of patient participation are compared in this paper. A literature review was conducted to examine empirical studies that focused on patient and/or family involvement during the bedside nursing handover from the patient and family perspective.

Background

The concept of patient participation is supported by the ethical principle of respect for autonomy, whereby individuals have the right to participate in their care on their own terms.^{2,11} A study by Eldh, Ekman and Ehnfors¹² showed that patients viewed participation as having knowledge, taking on responsibility, and collaborating with health care professionals. In addition, patients perceived participation to include health care professionals' respect for patient knowledge, being listened to, and receiving patient specific information.¹²

The concept of patient participation is important in today's nursing practice. The American Nurses

Association Code of Ethics, requires nurses to practice with compassion, dignity, and respect for the autonomy, worth, and uniqueness of every person.¹¹ Nurses are expected to protect the health, safety and rights of patients in their care.¹¹ The principle of respect for autonomy obligates nurses to honor the informed and voluntary decisions of their patients.¹¹ The code of ethics supports the nurse's role in sharing relevant information in a way that demonstrates compassion, dignity and uniqueness of the individual so that patients may use this knowledge and participate in their care based on their own values and beliefs.^{11,14} Resources based on the principle of respect for autonomy, such as the Interactive Care Model, are available to nurses and clinicians to facilitate an understanding of how patients can best participate in their health care.¹⁵

Viewed as a key component to improve population health, the concept of patient participation is significant in current healthcare policy in the United States and worldwide.¹⁵⁻¹⁶ The Institute for Healthcare Improvement's framework, known as the Triple Aim, aspires that individuals become better informed about what it takes to achieve health with an understanding of the benefits and risks of their current health care practices.¹⁷ In 2010 the passage of the Patient Protection and Affordable Care Act precipitated the authorization of the Patient Centered Outcomes Research Institute (PCORI).¹⁸ The aim of PCORI is to fund evidence-based research that will contribute knowledge to support patients in making informed decisions and thus improve outcomes.¹⁸ Globally, the World Health Organization (WHO) supports patient opportunities to become partners with health care providers and actively participate in self-management, and shared decision-making.¹⁹ WHO has identified the health care provider's role as pivotal in encouraging patient participation and in encouraging patient input.¹⁹ Ultimately changes in health care policy and rising health care costs have led to a paradigm shift where patients are viewed as active partners in their own health care, requiring knowledge of treatment options, share in decision making, and having greater responsibility for their own health outcomes.¹⁵⁻¹⁶

Methods

The scope of this paper was limited to patient and/or family participation that occurs during the nursing activity of the bedside handover among adult patients in a hospital setting. Articles were limited to include only studies that examined the patient and/or family perspective of the nursing handover when performed at the patient's bedside at the change of shift. The CINAHL database was used to search for empirical studies published in English and in peer reviewed journals from September 2007 to August 2017. Search terms included "bedside handover" or "nursing handover" or sharing health information" and "patient perspective". Article titles and abstracts were read

and chosen based on relevance to topic. Articles that did not provide the patient perspective or focused on the pediatric population were excluded. Final selection was made based on relevance to topic.

Historical Progression of the Concept of Patient Participation

Historically, patients were considered to be passive participants in health care,² while clinicians were trained and socialized as authoritarian providers of care.²⁰ The beneficence model, characterized as an authoritative physician and an obedient patient was the Hippocratic tradition.²⁰ It was the belief that only physicians had the knowledge and skills to decide what was best for their patients.²⁰ Physicians treated patients and made decisions based on their judgment without patient involvement.²⁰ It was not unusual for physicians to withhold potentially upsetting information from their patients.²⁰ Physicians justified this act with the belief that it was in their patient's best interests.²⁰ Society failed to challenge the Hippocratic tradition, and as a result the beneficence model continued until the end of the 19th century.²⁰ Ultimately questionable research practices and the lack of ethical guidelines led to a shift from the beneficence model to the autonomy model.²¹

The autonomy model is based on the premise that patients have the right to receive adequate information to make an intelligent decision regarding their care.²¹ The hallmark of the autonomy model, informed consent, asserts that patients must legally be provided with enough information to make an intelligent decision regarding their health.²¹ The autonomy model supports the participation of patients in the decision-making process based on the belief that patients know what is best for themselves.²¹

It wasn't until the 1960's, when the concept of patient participation first appeared in the literature.²² This was a time of great change in social and consumer rights.²² Individuals fought for the right to safety, right to be informed, right to choose, right to be heard and respect for autonomy.^{2,22} Ultimately, the patient's role evolved from a passive to an active participant in today's health care system.² Patients now participate in shared decision making, care planning, and in the management of their health conditions.² At the organizational level, patients are involved in creating educational programs, assist in establishing hospital policies, and participate on hospital quality of care and safety committees.²

Theoretical Perspectives of the Concept of Patient Participation

Just as the concept of patient participation has evolved over the years, so has nursing's theoretical approach to explain the relationship between patient, nurse, and

environment within today's health care system. Although numerous theories and models exist, this paper will discuss a select few to demonstrate the shift in the theoretical approach regarding patient participation.

Hildegard Peplau's interpersonal relations theory, originally published in 1952, focuses on the nurse-patient relationship.²³ Peplau's theory supports the need for respect for the dignity and worth of all individuals.²³ Nursing is seen as an interpersonal process, where nurse and patient interact towards a common goal.²³ During this process the nurse is expected to identify their patients' values and beliefs as it relates to their health care.²³ The nurse-patient interpersonal relationship is unique and allows for nurses to engage patients as active partners in their health journey towards a common goal.²³

Myra Levine's conservation model advocates for patient rights and privileges, patient-centered care, patient participation and decision making.²⁴ The basic principle of Levine's conservation model is maintaining wholeness of the individual through the process of adaptation using principles of conservation.²⁴ In nursing, conservation "means to maintain a proper balance between active nursing intervention coupled with patient participation on the one hand and the safe limits of the patient's ability on the other."²⁴ The concept of patient participation is found within the principle conservation of personal integrity, where self-identity, respect, and self-determination are key elements.²⁴ According to Levine, true conservation calls for the nurse to accept the level at which the patient chooses to participate²⁴, thus leading to nursing care that is patient-centered.

Imogene King's theory of goal attainment is based on an open system's approach whereby the personal, interpersonal, and social systems interact together with the environment.²⁵ Goal attainment is dependent upon mutual respect for an individual's ability to participate in their plan of care.²⁶ In this theory information is shared, mutual goals are determined, decisions are made to achieve goals, and a plan is implemented.²⁵ Verbal communication and listening are important components within the interpersonal system, where information is shared when individuals actively participate.²⁵ Interactions between nurse and client, such as communication and mutually valued decision making are referred to as transactions, and when successful, result in goal attainment.²⁶

A more contemporary nursing framework, the Interactive Care Model (ICM), places greater emphasis on patients having control over their health care decisions.¹⁵ The ICM has strong parallels to the nursing process and is a transformation from earlier nursing frameworks. This model provides the components for a partnership to which both patient and provider are recognized as experts; bringing to the table their own skills and knowledge.¹⁵

Unique to this partnership are various roles that patients and providers may draw upon to support patients participating in their health care.¹⁵ As partners, both patient and provider establish mutual goals and set outcomes.¹⁵ The ICM, a care delivery model, fosters patients to take greater ownership of their health.¹⁵ The ICM was developed to improve population health through patient engagement and partnerships between health care providers and patient to improve patient outcomes.¹⁵

The Patient Health Engagement model (PHE), based on consumer health psychology, views patients as having a personal choice to change from a passive to an active partner with their health care provider.²⁷ The model consists of four phases: blackout, arousal, adhesion, and eudaimonic project.²⁷ Patients feel overwhelmed and unable to manage their health in the blackout phase, but through engagement may progress to the eudaimonic project where patients actively participate in their health, are goal-oriented, and effectively navigate the health care system.²⁷ Health care professionals play an important role in motivating individuals to self-manage their care.²⁸ The ability of the provider to encourage individual autonomy in their care influences the individual's ability to actively participate in their health journey.²⁸

Ethical considerations such as respect for dignity, individual worth, self-determination, mutual respect, and autonomy were common themes within all theories discussed.^{15,23,24,25,27} Despite various definitions for patient, the more contemporary theories support the trend in which the role of patient has expanded to include partner and consumer.^{15,29} Patient participation activities such as communication, shared decision making, care planning and goal setting are all components within each of the theories presented.^{15,23,24,25,27} However, the more contemporary PHE model and ICM have expanded patient participation activities to include decision aids, electronic health records, patient portals, mobile applications, and online health information.^{15,28} Further, the theories shared the perspective that nurses should accept the individuals' ability and willingness to participate in their health care to the extent that they are able or desire.^{15,23,24,25,27}

The ICM and King's goal attainment theory, both based on systems theory, include the concept of a social system interacting with individuals and the environment.^{15,25} In the era of rising health care costs and healthcare reform, the ICM and the PHE model place a greater emphasis on health promotion and global health.^{15,29} Environmental components of the ICM include population health, community readiness, health care systems, and the provider practice environment, which ultimately impacts the individual.¹⁵ In King's theory, the social system consists of groups that exist in society, and while not specifically stated could include the global population.²⁵

Empirical Studies Related To The Nursing Bedside Handover

Eight studies related to patient and family participation during the nursing bedside handover are presented, as shown in Table 1. Four studies were conducted in Australia. One study was conducted in each of the following countries: United Kingdom, Italy, Israel and the United States. All eight studies were published between 2011 and 2017, with four published during the 2016 and 2017 period. Apart from the study by Drach-Zahavy and Shilman,⁴ all studies from 2011 to 2016 were qualitative in method. Qualitative research designs tend to be used when little is known about the concept,³⁰ and the purpose is to describe the subject's experience.³¹ This may explain the frequent use of qualitative methods among the earlier studies reported in this review. Confidence in the qualitative research evidence comes from the rigor of the methodological approach based on the research question, research tradition, design elements, data collection, sample and analysis of data.³⁰

Qualitative study methods used in this review included case study interviews, semi-structured interviews, and observations of nursing bedside handover and ward routine. A case study approach was used to analyze patient perceptions,³² and family perceptions of the nursing bedside handover.³³ McMurray and colleagues³² used convenience sampling to recruit subjects from one of two medical units in a hospital located in Australia. Four themes identified from the patient perspective on the nursing bedside handover included: 1) acknowledging patients as partners, 2) amending inaccuracies, 3) passive engagement, and 4) handover as interaction.³² Patients perceived that nurses treated them as individuals and recognized them as knowledgeable partners with a right to their medical information.³² In addition, patients held the belief that the bedside handover provided an opportunity for patients to correct inaccuracies of their medical information.³² However, some patients preferred a more passive participation during the bedside handover, and others needed to be directly encouraged to participate by the nursing staff.³² Patients achieved a sense of satisfaction when invited to interact and ask questions during the bedside handover.³²

Tobiano and colleagues³³ conducted semi-structured interviews and observations of family members' involvement during the nursing bedside handover at a single rehabilitation unit. While no men volunteered for the study, the sample consisted of four wives and four daughters once data saturation was met.³³ The first theme identified from the data included family members understanding the situation which included understanding the patient condition, nursing treatments, and plan of care.³³ The next theme was interacting with nursing staff which consisted of sharing information, clarifying

incorrect information, asking questions, assisting with patient care and interpreting information for the patient when the patient was too ill to participate.³³ A family member seeking more information offered, "...I feel free to ask questions if I wanted to."³³ The final theme of finding value consisted of feeling included, feeling at ease, valuing the individual, preparing for discharge, and privacy.³³ Family members viewed that the benefits to exchanging accurate information during the bedside handover offset the potential negative effects of a breach of patient privacy.³³ Although certain health related conditions kept some patients from actively participating during the handover, family members felt obligated to participate on behalf of the patient.³³ The authors acknowledged that while the all-female sample was a study limitation, effort was taken to interpret the data without any bias.³³

Studies by Kerr et al,³¹ Lupieri et al,³⁴ and Bruton et al³⁵ used qualitative descriptive methods involving semi-structured interviews to explore the bedside handover. Bruton and colleagues included observations of the unit routine, station handovers, bedside handovers, and multidisciplinary team meetings.³⁵ The settings included an emergency department,³¹ cardio-thoracic ICU,³⁴ and medical and surgical units.³⁵ Finding showed that patients preferred being involved, informed, and having opportunity to clarify inaccurate information during the nursing bedside handover.^{31,34-35} "Hearing the handover is wonderful because I can turn around and say you forgot something."³¹ However, for some patients being informed was a negative experience, especially when health information was considered worrisome: "You know, patients are nervous when they are told there isn't good news..."³⁴ Other patients described being awoken from sleep for the handover and felt that it was too disruptive to be conducted at the bedside.³⁵ Inconsistencies were found in patients' desired level of participation.³⁵ Some patients wanted more participation, others wanted less, and some patients only wanted to listen to the bedside handover.³⁵ The use of medical jargon did limit patient participation, as it impeded patients' ability to participate in the conversation.³⁴ Despite this finding, participation in the bedside handover increased patients' confidence in nursing care.³⁴ Patients expressed value in witnessing the nurses' humanity and professionalism as they exchanged information with the patient during the handover.³⁴ Most patients did not believe their privacy and confidentiality were violated, provided the bedside handover was conducted at the bedside,³¹ and the nurses spoke softly.³⁴ In fact, most patients believed the benefits of participating in the bedside handover outweighed the risks of compromising their confidentiality.³⁴

A study by Drach-Zahavy and Shilman⁴ applied a mixed methods approach to examine the characteristics of the bedside nursing handover, patients' personal traits, and

patient participation during the bedside handover. Based on a power analysis, a random selection of 100 handovers were observed from five different surgical units of a large medical center in Israel.⁴ Patient initiative to participate, nurse initiative to participate, presence of head nurse, and presence of visitors were measured as dichotomous variables (1=yes, 0=no) and analyzed using logistic regression analysis.⁴ The S(FFI) Neo-Five factor inventory was used to measure patient personality traits of agreeableness, conscientiousness, neuroticism, extraversion, and openness to experience.⁴ This 60 item questionnaire has adequate reliability and validity.⁴ Findings showed that patient initiative towards participation during bedside handover was higher in the presence of the head nurse ($p < 0.05$), and both nurse initiative ($p < 0.05$) and patient initiative ($p < 0.05$) was higher in the presence of family and visitors.⁴ Patient personality traits, as measured by the S(FFI) Neo-Five factor inventory, showed that patients high in neuroticism ($p < 0.05$), and agreeableness ($p < 0.05$) were more likely to participate during the bedside handover.⁴ Patient personality traits of neuroticism ($p < 0.05$), extraversion ($p < 0.05$), and conscientiousness ($p < 0.05$) were negatively associated with nurse's initiative towards participation during the bedside handover.⁴ In other words, patients high in neuroticism, extraversion, and conscientiousness were less involved during report, suggesting that nurses keep talkative patients from intervening and dominating the conversation.⁴ Overall the most common type of communication was clarifying patient care, and that most communication was initiated by the patient.⁴ Patients perceived the bedside handover as an opportunity to obtain information, understand the plan of care, and understand medical jargon.⁴

Benham-Hutchins et al³⁶ conducted an exploratory study consisting of an online survey. The survey used open ended questions to elicit patients' perceptions about self-management during hospitalization, and participation in the nursing bedside handover.³⁶ Patient self-management and level of engagement in self-care were measured using the Patient Activation Measure (PAM).³⁶ The instrument is described as a 10-item, 4-point Likert type scale with strong psychometric properties.³⁶ Convenience and social media snowball sampling was conducted to enlist a total of 34 participants.³⁶ Although most studies in this review were conducted at single site settings, the sample in this study represented all four geographical areas of the U.S. as well as urban, suburban and rural settings.³⁶ Findings of the PAM measure showed that 31 of the participants scored at the higher end of the scale, indicating a group that actively participates and self-manages their care.³⁶ Participants described a range of patient participation activities during their hospital stay such as having a whiteboard in their room (71%).³⁶ Only 29% of participants ($n=10$) reported experiencing the bedside handover, with all ten respondents reported listening to

the handover, four respondents asked questions, five respondents answered questions and two made corrections.³⁶ Qualitative analysis identified 6 themes including patient preference to be involved in the bedside handover, wanting to know everything about their medical care, the patient feeling ignored and not listened to, expectations about communication and care coordination, and tracking inpatient and outpatient health information.³⁶

Whitty et al⁸ used a discrete choice experimental (DCE) design to identify and compare patients' and nurses' preferences for the nursing bedside handover. Described as a type of survey, DCE is used to determine the preferences related to an aspect of health care, in this case the nursing bedside handover.⁸ Discrete choice experiments are used frequently in health care to study preferences of patients and stakeholders.³⁷ Semi-structured interviews with 20 patients and 20 nurses were used to identify attributes of patient participation in the bedside handover.⁸ Based on DCE sample size guidelines, a target sample of 400 patients and 200 nurses was established.⁸ A total of 401 patients and 200 nurses from two large tertiary referral hospitals completed the survey.⁸ Findings showed that both nurses and patients preferred the bedside handover ($p < 0.05$).⁸ Preferences ranked most important by patients was being invited to participate, followed by asking questions, speaking up and hearing what is being said, and having a family member present.⁸

Conclusions

The purpose of this paper was to present historical and theoretical background information as it related to the concept of patient participation and to present an analysis of empirical studies related to the nursing bedside handover from the patients' perspective. Overall studies in this paper show support for patients' desire to participate during the nursing handover as it occurs at the bedside. Patients want to be invited in this activity and view the bedside handover as contributing to their care. The nursing bedside handover promotes the sharing of information, communication, and the opportunity to clarify and correct inaccuracies. It remains unclear why some patients prefer higher levels of participation, and others prefer lower levels of participation or even non-participation in this activity. Patients that participated in the nursing handover felt included, experienced enhanced care, and had more confidence in nursing staff. Patients also reported feeling informed, having greater control and feeling like a partner. Some patients did report that participation in the bedside handover was at times disruptive and potentially the health information discussed was worrisome. None of the studies presented in this paper measured any patient outcomes such as change in patient knowledge or length of stay. Barriers to patient participation during the bedside handover included talkative nurses, feeling ignored and not listened to, patient

illness, and the use of medical jargon. Most patients did not perceive the bedside handover as compromising their privacy and confidentiality provided nurses took steps to protect it.

Patient participation within the nursing activity of the bedside handover is an important and understudied component of nursing. Further research to understand patient preferences in their level of participation during the nursing bedside handover is recommended. Additional research should focus on whether the nursing bedside handover is associated with outcomes such as length of stay, medication knowledge and adherence to the plan of care. There is also a need to further investigate whether differences in patient participation during the bedside handover are correlated with gender, age, race/ethnicity, education, and socioeconomic status. Finally, further understanding of facilitators and barriers to patient and family participation during the bedside handover may provide nurses with strategies to encourage patient and family participation.

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Table 1. Summary of Empirical Studies

Author Title Year	Purpose	Method	Sample/Setting	Results	Country
McMurray et al. Patient's perspectives of bedside nursing handover. 2011	To understand patients' perceptions of nursing bedside shift to shift handover.	Descriptive case study Interviews were analyzed using thematic content analysis.	Convenience sample of 10 patients, (6 females and 4 males). Setting Medical unit in a hospital in Australia	Four themes: 1 acknowledging patients as partners. 2. Amending inaccuracies. 3. Passive engagement. 4. Handover as interaction.	Australia
Tobiano, Chaboyer, & McMurray. Family members' perceptions of the nursing bedside handover. 2012	To examine families' perceptions of the bedside shift to shift report.	Qualitative, case study methodology. In-depth semi-structured interviews, observations and field notes. Coding and categorization of data to identify themes	Convenience sample of participants with family members at one rehabilitation unit in Australia. N=8 women, (4 wives, 4 daughters).	Three themes: 1 Understanding the situation. 2. Interacting with nursing staff. (asking questions). 3. Finding value (feeling included), preparing for discharge, and maintaining privacy.	Australia
Kerr et al. Attitudes of emergency department patients about handover at the bedside. 2013	To explore patients' perspectives of bedside handover by nurses in the emergency department.	Qualitative descriptive method using semi-structured interviews and thematic content analysis to identify themes.	Purposive sampling of patients from a tertiary urban emergency department in Australia. N=30 participants (18 females, 12 male).	Themes: 1. Patient perception, participating in bedside handover enhances individual care and clarifying information. 2. Maintaining privacy during handover.	Australia
Drach-Zahavy, & Shilman. Patients' participation during a nursing handover: The role of handover characteristics and patients' personal traits. 2015	1. To examine patients' participation in the handover. 2. Evaluate how patient's personality attributes are linked to patients' participation. 3. Evaluate these effects beyond high nurse patient ratios and presence of family.	Cross-sectional design using both qualitative and quantitative methods. Observations of handover. Content analysis of handover conversations. S(FPI) Neo-Five factor inventory was used to measure personality traits.	Random selection of 100 nursing handovers (100 patients and 100 nurses) from 5 surgical wards in a large medical center in Israel over a one-year period.	Initiative to participate was statistically significant for re-admitted patients, and females. Exchange of information helped plan care and take charge. Inadequate staffing associated with less nurse initiative to participate.	Israel
Lupieri, Creatti, & Palese. Cardio-thoracic surgical patients' experience on bedside nursing handovers: Findings from a qualitative study. 2016	To describe the experiences of postop Cardiothoracic surgical patients experiencing nursing bedside handover.	Qualitative descriptive study. Semi-structured interviews consisting of 6 open ended questions to guide data collection. Nine interviews took place on the second post-op day, and five took place between the third and fourth post-op day.	Purposive sampling. Setting: 10 bed cardio-thoracic ICU in Italy. N= 14 participants (10 males and 4 females).	Four themes identified: 1. Discovering a new nursing identity. 2. Limited participation in bedside handover. 3. Experiencing the paradox of confidentiality. 4. Having the situation under control (verify accuracy of information).	Italy
Bruton et al. Nurses' handover: Patient and staff experiences. 2016	To understand the purpose, impact and experience of nurse-to-nurse handover from both patient and staff perspectives and the perceived differences between nurse handover and medical ward rounds.	Qualitative and observational study. Semi-structured interviews. Observations of ward routine, 4 ward rounds, 12 nurse office/station handovers, 3 multidisciplinary team meetings and 12 bedside handovers.	Convenience sampling. Setting: 23 bed medical ward and 26 bed surgical ward in UK. Participants included 8 patients, 10 nurses, 1 student nurse, 3 healthcare assistants, 1 doctor and 1 physiotherapist.	Patient and nurse both view handover as information sharing between nurses, views varied regarding role of patient. Style affected degree of patient involvement. Some patients were involved, others listened. Nurse assistants did not participate in the bedside report.	UK

Table 1. Summary of Empirical Studies (cont'd.)

Author Title Year	Purpose	Method	Sample/Setting	Results	Country
Whitty et al. Patient and nurse preferences for implementation of bedside handover: Do they agree? Findings from a discrete choice experiment. 2017	To identify and compare patients' and nurses' preferences for the implementation of bedside handover.	Discrete choice experimental design.	Sampling method not reported. Setting: Medical wards from a 750-bed public hospital and 500 bed private hospital in Australia. N=401 patients N=200 nurses	Both patient and nurse preferred bedside handover ($p < 0.05$). Characteristics most important: (1) invited to participate in handover, (2) ask question, being able to speak and hearing what is said, (3) having a family member present.	Australia
Benham-Hutchins et al. "I want to know everything": A qualitative study of perspectives from patients with chronic diseases on sharing health information during hospitalization. 2017	The purpose of this research was to describe patients' perceptions about self-management during hospitalization and the immediate time period after discharge, information access during hospitalization and participation in nursing bedside handoff.	Exploratory study. Online survey about hospital experience, Patient Activation Measure (PAM), and demographics. Conventional qualitative content analysis of open-ended questions.	Sampling: Convenience and social media snowball sampling (SMSS) through online patient support groups, email invitation, listservs, blogs, and social media. Setting: individuals across urban, suburban, and rural areas. N=34 Participants	Ages 20 to 76 ($\mu=48$, $SD=16.87$). PAM level 1 ($n=0$), level 2 ($n=3$), level 3 ($n=21$), level 4 ($n=10$). Only 29% had bedside handover, 4 reported being invited to participate. During handoff: 10 respondents listened, 4 asked questions, 5 answered question, 2 made corrections. Qualitative analysis: 6 themes.	USA