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Nurses' shift reports: A systematic literature search and critical review of qualitative field studies

Running head:

Field studies of nurses' shift reports

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NURSES' SHIFT REPORTS: A SYSTEMATIC LITERATURE SEARCH AND CRITICAL REVIEW OF QUALITATIVE FIELD STUDIES

ABSTRACT

Aims and Objectives

The aim was to identify reporting practices that feature in studies of nurses' shift reports across diverse nursing specialities. The objectives were to perform an exhaustive systematic literature search and to critically review the quality and findings of qualitative field studies of nurses' shift reports.

Background

Nurses' shift reports are routine occurrences in healthcare organisations that are viewed as crucial for patient outcomes, patient safety and continuity of care. Studies of communication between nurses attend primarily to 1:1 communication and analyse the adequacy and accuracy of patient information and feature handovers at the bedside. Still, verbal reports between groups of nurses about patients are commonplace. Shift reports are obvious sites for studying the situated accomplishment of professional nursing at the group level. This review is focused exclusively on qualitative field research for nuanced and contextualised insights into nurses' everyday shift reporting practices.

Design

The paper is a systematic literature search and critical review of qualitative field analyses of nurses' shift reports. We searched in the databases CIHAHL, PubMed and PsycINFO and identified and reviewed 19 articles published 1992 to 2014. Data were systematically extracted using criteria for the evaluation of qualitative research reports.

Results

The studies described shift report practices and identified several factors contributing to distribution of clinical knowledge. Shift report practices were described as highly conventionalised and locally situated, but with occasional opportunities for improvisation and negotiation between nurses. Finally, shift reports were described as multifunctional meetings, with individual and social effects for nurses and teams.

Conclusion

Innovations in between-shift communications can benefit from this analysis, by providing for the many functions of handovers that are revealed in field studies.

Relevance to clinical practice

Leaders and practising nurses may consider what are the best opportunities for nurses to work up clinical knowledge and negotiate care.

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

- Nurses' clinical knowledge during shift reports is socially, organisationally and materially distributed.
- Shift report practices are highly conventionalised and dependent on local norms and routines for their structure, but with occasional opportunities for improvisation and negotiation.
- Shift reports are multifunctional meetings with individual and social effects.

Key words (CINAHL):

Continuity of Patient Care
Hand Off (Patient Safety)
Health Information Systems

Nurses

Nursing knowledge

Professional Practice

Patient Safety

Systematic Review

Shift reports## INTRODUCTION

Nurses' shift reports are routine occurrences in healthcare organisations that take place when some nurses finish working and other nurses start working. In recent years, literature reflects innovations in between-shift communications, such as information from outgoing shift provided as an audio recording, and 1:1 bedside handovers replacing meetings between successive shifts of nurses (Anderson *et al.* 2015, Holly & Poletick 2014). The 1:1 bedside handover predominates in some areas, such as critical care nursing. Many studies of nursing communication are centred on the adequacy of such 1:1 communications, whether for escalating care of a deteriorating patient or for routine handover reports at the bedside (Braaf *et al.* 2015). Never the less, communication events between groups of shift-working nurses still occur across many hospital settings. The shift report remains a rich site for studying the professional work of nursing and has continued to receive attention via ethnographic research. The aim of this paper is to explore the existing field studies of shift reports, to bring forward the features and functions of such group level practices.

Nurses' shift reports can be viewed as a sub-type of organisational "handoffs" or "handovers", which may involve other healthcare professionals and have other organisational purposes, such as patient transfer or patient discharge. In this study, we used the term "shift report" in accordance with CINAHL's controlled headings. Nurses' oral and written communication at shift reports is central for organising their work (Allen 2014), it externalises their clinical awareness and professional accountability (Buus & Hamilton 2016), and the communicative exchange is regarded as crucial for patient safety and continuity of care (Anderson *et al.* 2015, Kitson *et al.* 2014, Staggers & Blaz 2013).

In their seminal paper, Parker et al. (1992) discussed why nurses' shift reports continued to survive to that day through the many changes in health care organisations, and they suggested that it was because shift reports have important professional and psychosocial

functions, beyond transmitting clinical knowledge. As a meeting among professional peers, the shift report was viewed as an opportunity to discuss and demonstrate professional competencies and to seek group validation. The paper inspired a group of subsequent studies of the multiplicity of functions taking place during shift reports and of shift reports as important events for enacting nursing professionalism. These studies have been paralleled by a larger - and rapidly growing - group of studies examining clinical issues related to shift reports, such as effectiveness, patient safety, standardisation and information transfer.

Background

There is neither a widely accepted definition of "hospital handoff" (Cohen & Hilligoss 2010) nor of "nurses' shift report". In an early and widely cited study, Clair and Trussell defined change of shift reports as "communication of pertinent information about patients […] that emphasizes events of the tour of duty just ending." (Clair & Trussell 1969, p. 91). For Clair and Trussell, the purpose of the shift report was to secure continuity of care, and they suggest that the basic content of a report included: identifying patient information, general patient information, nursing directives and special problems (Clair & Trussell 1969).

Since group handovers feature in practice and the literature, sometimes combined with bedside 1:1 handovers (Johnson *et al.* 2016), an updated definition and exploration of handover is warranted. We suggest an update of Clair and Trussell's definition, by qualifying three central issues inherent in it. *First*, Clair and Trussell's definition of the purpose of shift reports - as securing continuity of care - does not sufficiently account for the organisational, social and individual functions also taking place during nurses' shift reports, compare with (Hays 2003, Staggers & Blaz 2013, Strople & Ottani 2006). Shift reports are multi-functional, and we eschew an *a priori* ranking of the different functions, for example by privileging continuity of care over reinforcement of group cohesion. *Second*, Clair and Trussell's notion of communication implies a simple one-way transmission of information, which does not sufficiently account for how an individual nurse and groups of nurses are actively engaged in the (co-)production of clinical knowledge within the social and material constraints of the shift reports, cf. (Hilligoss & Cohen 2011). In this context, "clinical knowledge" entails all the elements of practical nursing knowledge, such as facts, findings, representations, opinions, diagnoses, etc. (Buus 2008). *Third*, Clair and Trussell state that nurses' shift reports contain

pertinent information and suggest a basic structure of the content of the record. Again, we do not advocate for an *a priori* definition of what counts as timely and accurate information in the shift report context or how information should be structured, such as suggested by Clair and Trussell. However, we wish to emphasise that the situated interests of nurses ending their work shift and of nurses starting their work shift will heavily influence which information is deemed "pertinent". Different nurses anticipate differently what they need to know about their work shift and incoming and outgoing nurses do not share the same need for communication at shift reports (Hill & Nyce 2010, Kitson *et al.* 2014, O'Brien *et al.* 2016). Our updated definition of nurses' shift reports is that it is *a multi-functional communication process where nurses individually and collaboratively produce clinical knowledge as some nurses' work shift ends and other nurses' work shift begins*. This definition and the rational provided is reflected in the criteria for selection of studies in this review.

Two recent meta-studies focused exclusively on nurses' shift reports. Kitson et al. (2014) performed a narrative review and synthesis of 29 papers reporting from both qualitative and quantitative studies of nursing shift reports in adult acute care hospital wards. Holly and Poletick (2014) performed a systematic review and meta-synthesis of 29 qualitative studies focused on acute hospital nurses' experiences of shift reports and what influences information transfer in these shift reports. In both meta-studies, the inclusion and exclusion criteria were not reported transparently, e.g. definitions of "acute care" (Kitson *et al.* 2014, p. 1230) and criteria for the exclusion of "unworthy" (Holly & Poletick 2014, p. 2389) studies, and therefore we were unable to determine whether the literature searches were complete. Moreover, the two meta-studies were indicative of some important challenges associated with reviewing research on nurses' shift reports. Previous reviews have been relatively inconclusive about the key characteristics of shift reports. For example, the two above-mentioned reviews reported only very broad issues related to shift reports, which was most probably linked to a strong tendency towards including research based on many different types of studies. Furthermore, Kitson et al. (2014) observed that it was difficult to summarise and interpret studies selected for a review because they did not draw on explicit theory or on the same core concepts and because they had been designed to fulfil different research purposes, e.g. implementing a standard for shift reports or implementing new technology into the shift reports.

Considering Kitson et al.'s (2014) observation about the difficulties of summarising research in this area, we decided to systematically review a specific sample of qualitative field analyses of nurses' shift reports. Qualitative field studies are here defined as including observation-based and unstructured data, that can give nuanced and contextualised insight into the key characteristics of the organizational practices of producing clinical knowledge. To our knowledge, this particular type of research has not been reviewed previously. We critically reviewed studies and findings in this area of research, which enabled us to identify under-researched topics and suggest an agenda for future research.

METHODS

Aim

The aim of this study was to perform an exhaustive systematic literature search and critical review of qualitative field studies of nurses' shift reports across all nursing specialities. In particular, we focus on

- the studies' contributions to our understanding of the social and material distribution of clinical knowledge at nurses' shift reports in the context of everyday practice, and
- the methodological quality of the analyses of nurses' shift reports.

The review is critical in the sense that we will use the review's findings to make nurses aware of contradictions in beliefs about shift report practices.

Design

This study was designed as a systematic literature search and critical review of papers reporting qualitative field analyses of nurses' shift reports.

Search methods

The aim of the systematic literature search was to identify all studies within a selective sampling frame (Cooper 2010), in this case all qualitative field studies of handovers. The

search took place in September-November 2014. We searched in the reference databases CIHAHL, PubMed and PsycINFO using both controlled and free text search terms. The search strings were:

- CINAHL: ((MH ”Shift reports”) OR ”Change of shift reports” OR Handoff* OR Hand-off* OR Handover* OR Hand-over* OR ”Intershift report” OR ”Nursing report” OR ”Shift change” OR Signoff* OR Sign-off* OR Signout* OR Sign-out* OR Signover* OR Sign-over*) AND ((MH “Qualitative Studies+”) OR Audio-recording OR “Ethnographic research” OR Ethnography OR “Field notes” OR Fieldwork OR Observation OR “Participant observation” OR Videorecording OR “Video-recording”). This search string identified 221 references.
- PubMed: (“Patient handoff”[MeSH] OR ”Change of shift reports” OR Handoff* OR Hand-off* OR Handover* OR Hand-over* OR ”Intershift report” OR ”Nursing report” OR ”Shift change” OR Signoff* OR Sign-off* OR Signout* OR Sign-out* OR Signover* OR Sign-over*) AND (“Qualitative studies”[MeSH] OR Audio-recording OR “Ethnographic research” OR Ethnography OR “Field notes” OR Fieldwork OR Observation OR “Participant observation” OR Videorecording OR “Video-recording”) AND Nurs*. This search string identified 358 references.
- PsycINFO: (”Change of shift reports” OR Handoff* OR Hand-off* OR Handover* OR Hand-over* OR ”Intershift report” OR ”Nursing report” OR ”Shift change” OR Signoff* OR Sign-off* OR Signout* OR Sign-out* OR Signover* OR Sign-over*) AND Nurs*. This search string identified 154 references.

We systematically searched for “similar”/”related” references of relevant references in the three databases and for ancestry and decadency references of relevant references in the citation index SCOPUS.

The use of controlled search terms in CINAHL and PubMed provided some level of both precision and recall, but because we were interested in a sub-sample of studies of shift reports, the searches were characterised by relatively low precision and high recall. The first author initially read title and abstract of the majority of references, including examining 129 full text papers, and screened out the larger proportion of irrelevant references. This preliminary screening led to the identification of 40 full text references, which were read independently by two assessors. If the two assessors disagreed, a third assessor would also

evaluate the paper, which would be screened in or out on the basis of a joint discussion and consensus decision. The decision to include several assessors in the final stages of the screening process was to stimulate discussions about the exact execution of the inclusion and exclusion criteria.

Inclusion criteria:

- Qualitative studies of naturally occurring, non-experimental nursing shift reports that include observation-based data.
- Primary research published in English language journals.

Exclusion criteria:

- Studies of shift report sub-types, such as bedside shift reports, audio-recorded shift reports, etc. These studies were excluded because they did not provide the same level of insight into the wider organisation of nursing handover practices.
- Papers where the study of shift reports only play a minor role.
- Highly structured, deductive content analyses. Some content analyses were structured to the extent that the open-endedness that characterises qualitative inquiry was not present. While some were named "qualitative", we did not regard them as such.
- Studies reported in very poor English. Two studies were written in English that was so unclear that we found it impossible to understand and describe the study, methods and findings, with the necessary confidence.

The decision to search for only original English language journal papers was taken for pragmatic reasons, to reduce the scope and complexity of the search.

Appraisal and data extraction

The aims of the review were to describe the included studies, to systematically appraise the quality of the studies, and to systematically compare and summarise their findings. There is no consensus on how to exhaustively evaluate the quality of qualitative research in a uniform way (Hammersley 2008), and we chose to use the 20 overall items of *the criteria for the evaluation of qualitative research reports* (Blaxter 2013) as a structured outset for our appraisal (see table 1). *The criteria* include central and general items that can encompass

most types of qualitative healthcare research and their openness served to sensitise our reading and discussions about explicit and implicit indicators of quality in the descriptions of the studies, compare with (Dixon-Woods *et al.* 2007, Seale 1999). The criteria's emphasis on methods and presentation suited our acquired "taste" (Sandelowski 2015) for appropriately judging this type of study. Two appraisers extracted data from each paper by means of *the criteria*, with a special focus on research aim, theoretical framing, study context, data, data-analysis, and findings. The reason for having multiple appraisers was to stimulate discussions and generate nuanced and balanced descriptions of the papers' qualities. In line with Noblit & Hare (1988) and others (Dixon-Woods *et al.* 2007, Torrance 2008), we favoured the potential contribution of a paper to the review rather than judging procedural aspects of the studies, and the aim of the evaluation phase was therefore to describe the studies and to assess their quality, not to exclude eventual low-quality articles.

[Insert table 1 around here]

RESULTS

The reviewed studies reported and analysed an array of formal and informal communication practices in shift reports that occurred routinely across a diverse range of specialist areas of nursing practice. In this section, we briefly introduce the reviewed studies followed by a presentation of their contribution to our understanding of the production of clinical knowledge at nurses' shift reports, presented under five inductively derived themes. The themes are not discrete because most studies touch on several issues and we present the studies according to their most prominent findings. Last, we will review the methodological quality of the study by emphasising key methodological and theoretical issues.

1. The field studies

We identified and reviewed 19 articles published between 1992 and 2014. The majority of papers were published in nursing journals. Five of the articles were identified in all three reference databases. Ten articles were located only in CINAHL and PubMed. One article was

located only in PsycINFO, and three articles were identified outside the three reference databases through the searches in SCOPUS. This distribution of articles across databases indicated that a search in either CINAHL or PubMed in combination with a search for ancestry and decadency references in SCOPUS would most probably result in the same level of recall.

Considering the whole sample of papers, there was a increasing tendency over time towards emphasising clinical issues related to shift reports compared to earlier studies' emphasis on nurses' professionalism. One study was reported in two papers. The studies (n=18) originated from Australia (n=5), England (n=4), France (n=1), Iran (n=1), North America (n=3), Scandinavia (n=3), and Switzerland (n=1). The settings included paediatric (in 3 papers), mental health (1), aged care (1), critical care (2), rehabilitation (1), surgical (9) and medical wards (9).

Studies varied as to how they defined the scope of a "shift report". In some studies a shift report included the period immediately before and immediately after the formalised report of clinical knowledge whereas other studies would focus exclusively on the formalised part of the report. Moreover, most studies enumerated "shift reports" as organisational occurrences, while some studies most probably enumerated shift reports as an occurrence concerning each individual patient, see for instance (Johnson *et al.* 2012, Staggers *et al.* 2011).

Abbreviated descriptions of the summaries of the studies are presented in table 1.

[Insert table 2 around here].

1.1 Conventionalised practices

The studies depicted shift reports as regulated and conventionalised organisational occurrences. A number of studies identified a phased structure of shift reports (Buus 2006, Ekman & Segesten 1995, Evans *et al.* 2008, Kerr 2002, Lally 1999, Payne *et al.* 2000, Strange 1996). Some described this process in terms of a staged handover of accountability and power from the outgoing nurses to the oncoming nurses (Ekman & Segesten 1995), while others described the shift report phases as moves in the level of interactional formality, where the

phase of actually reporting is significantly more formal compared to pre and post shift report phases (Buus 2006, Lally 1999, Payne *et al.* 2000, Strange 1996).

A group of studies focused particularly on studying conventionalised interactions during shift reports (Buus 2006, Grosjean 2004, Manias & Street 2000). Grosjean (2004) explored multi-participant talk in different clinical settings and sought to identify what triggered switches between a "dilogue" [sic.] with listeners, where the outgoing nurse controlled the conversational floor and addressed a specific oncoming nurse, and "polylogue" [sic.], which was characterised by participants other than the two main speakers feeling temporarily legitimised to speak. In a similar vein, Buus (2006) studied what nurses regarded as acceptable accounts of clinical knowledge and emphasised the switches between non-interactional shift reports, where the outgoing nurse would simply read aloud the most recent entries in patients' nursing records, and interactional shift reports that were characterised by discussions among the participants. Manias & Street (2000) and Liu et al. (2012) studied two-staged shift reports and found that nurse coordinators controlled communication processes during initial group shift reports taking place in locations separated from other ward activities. The highly regulated shift report practices strengthened organisational control and nursing hierarchies.

A few studies described the oncoming nurses' active search for information, such as anticipating workloads and posing probing questions to the outgoing nurses. Active information seeking could be challenged by nurses' social status and local norms, which closed down such activities (Buus 2006, Grosjean 2004, Strange 1996). The abovementioned studies emphasised that the handover of clinical knowledge at shift reports is socially distributed according to local norms, professional and social status, personal instinct, and the distribution of prior clinical knowledge.

1.2 Customising relevant clinical knowledge

The studies described different thresholds of relevancy as to the content and structure of the clinical knowledge handed over. A few studies evaluated the observed shift records based on pre-defined criteria for appropriate reporting, while most studies described local thresholds for appropriate reporting. Several studies described organisational constraints, in particular time, that influenced the relevancy threshold and hence the content of the reports. Time constraints tended to increase the focus on basic biomedical clinical knowledge and on

organisational issues, such as discharge etc., and to minimise queries made by the oncoming nurses (Buus 2006, Ekman & Segesten 1995, Liu *et al.* 2012, Manias & Street 2000, Payne *et al.* 2000).

In several studies, outgoing nurses were described as customising the clinical knowledge handed over to the particular audience (Engesmo & Tjora 2006, Kerr 2002, Manias & Street 2000, Parker 1996, Parker *et al.* 1992). This aspiration to make the reports relevant could be challenging because of different thresholds of relevancy; extra information may be redundant for some nurses, but beneficial for others (Buus 2006, Kerr 2002). Different specialities had different thresholds for relevant clinical knowledge. This was most probably linked to the (in)stability of a patient's health and length of stay, which could influence heavily the distribution of prior clinical knowledge, as the patient would be more or less known by individual staff members. Moreover, a common finding was that the clinical knowledge handed over was focused on taking care of patients in the near future, and if there were no immediate concerns or tasks, the outgoing nurses would provide short reports and categorise patients as unproblematic and "fine", see for instance (Johnson *et al.* 2012, Liu *et al.* 2012, Manias & Street 2000, Sarvestani *et al.* 2014). Therefore, customisation was primarily described as an economical focus on present issues and tasks, which most often reflected an adaption to organisational constraints and clinical concerns. However, customisation could also entail tailored elaborations of a patient's situation.

1.3 Language use

The studies emphasised different aspects of nurses' language use at shift reports: some studies focused on discursive content and speech delivery while other studies focused on how nurses accomplished "nursing work" through their particular language use. The former discursive group of studies found that the language at shift reports was primarily biomedical (Liu *et al.* 2012). Payne et al. (2000) and Staggers & Jennings (2009) found that the language primarily contained biomedical accounts, jargon, abbreviations and acronyms, and listeners had to be privy to the language use and to the situation to understand correctly. Furthermore, Payne et al. (2000) argued that a high-speed delivery of the report was considered to be a skilled performance. Other studies emphasised that nurses used a mixture of formal and lay language to categorize patients and work them into recognisable cases (Buus 2006, Evans *et al.* 2008, Parker *et al.* 1992, Strange 1996). Several studies reported that nurses described

patients in a stereotyped manner or in a particular or idiosyncratic manner, and that they expressed everyday assessments and moral, prejudice judgements (Parker 1996, Parker *et al.* 1992, Sarvestani *et al.* 2014).

The latter group of studies featuring the way language enabled nursing work, regarded nurses' collective storytelling as part of the everyday accomplishment of professional nursing at shift reports (Bangerter *et al.* 2011, Parker *et al.* 1992). Bangerter et al. (2011) used content analysis and conversation analysis to examine reported speech in nurses' narratives during shift reports. Nurses used reported speech as an effective rhetorical resource when they flagged non-routine events, displayed technical reasoning and/or legitimised the speaker's own recounted actions (Bangerter *et al.* 2011). The nurses' story telling at handovers was regarded as crucial for sharing and consolidating professional culture (Bangerter *et al.* 2011, Parker *et al.* 1992).

1.4 Drawing on written records

Several studies emphasised the writing practices among the oncoming nurses during shift reports and described how clinical knowledge was technologically distributed through the particular recording systems (Engesmo & Tjora 2006, Hardey *et al.* 2000, Staggers *et al.* 2011). Hardey et al. (2000) examined "scrap notes" taken during shift reports, which were characterised as highly personalised, dynamic and easily updated. The notes were typically a combination of to do lists and pertinent information that nurses needed to remember correctly, and the accessibility and convenience of the notes made them important sources of information at shift reports. Staggers et al. (2011) found that computerised patient summary reports did not provide nurses the cognitive support they needed at shift reports and nurses preferred more flexible and personalised paper notes for the shift report. Both Hardey et al. (2000) and Staggers et al. (2011) interpreted the informal and personalised notes in use at shift reports as a response to the perceived inadequacy of formal documentation systems. Engesmo & Tjora (2006) examined the consequences of replacing face-to-face shift reports with shift reports based on written records and concluded that face-to-face shift reports were crucial because this mode of report allowed the a customisation of precise clinical knowledge according to immediate needs.

1.5 Norms and functions

While the transfer of clinical knowledge is commonly articulated as the formal and primary function of shift reporting, several studies identified an array of concomitant functions. These predominantly psychosocial functions were mainly related to collective assessment and decision-making and to group identity work, which added to a sense of belonging and of common understanding (Buus 2006, Kerr 2002, Lally 1999, Parker *et al.* 1992, Strange 1996). While most studies described nurses' discussions as a positive contribution to group coherence, a few studies (Buus 2006, Ekman & Segesten 1995, Manias & Street 2000) argued that giving case presentations could provoke anxiety and fear, because it would disclose a nurse's own clinical practices and, perhaps, ignorance. Buus (2006) argued that nurses colluded to avoid challenging interrogations and that they preferred to display an unchallenged sense of mutual understanding, while Manias & Street (2000) argued that oncoming nurses were dismissive towards outgoing nurses and they would subtly indicate that order would be restored on the next-coming shift. Manias & Street's (2000) key point was that nurses were conforming to idealised, but unspoken clinical norms about tidiness, busyness, and finality that punished those nurses who wanted to focus on handing over clinical deficiency and disorder. On the basis of psychoanalytic theory, Evans et al. (2008) argued that handover practices were ritualised and organised to alleviate anxiety caused by prohibited knowledge. The shift report meeting was examined as a social event, and the studies identified both beneficial, anxiety-reducing effects and destructive, anxiety-provoking effects of the meetings.

2. The quality of the studies: contextualising and theorising

In this section, we focus on the quality of the reported studies. In this evaluation, we systematically used the *criteria for the evaluation of qualitative research papers* (Blaxter 2013). Here, we report some of the most central findings from the evaluation: contextualisation of research and presentation of original evidence (item 14 and 17) and the connection to existing theory and use of theory in the analysis (item 2 and 10).

Contextualisation is about presenting information in meaningful and appropriate situations and it concerns both particular study contexts and original data extracts. The significance and transferability of the studies' results were difficult to assess and compare between studies, because of limited contextualisation. Only a few studies provided comprehensive and

organisationally situated descriptions of the specific shift report practices, a deficiency earlier noted by Manias and Street (2000). Furthermore, the issue of contextualisation raises a question regarding which data are relevant, and may be necessary, for understanding what goes on during nurses' shift reports. The studies very rarely included information about different statuses of nurses (formal and informal), the distribution of prior clinical knowledge, local norms, etc. These are all are factors that could have a significant influence on the shift reports (see section 1.1 above). Finally, limited contextualisation made it difficult to assess the relationship between the presented data, which tended to be limited, and the conclusions drawn by the authors.

The articles introduced a range of concepts and theories for understanding nurses' shift reports and, more generally, for examining social interaction at shift reports. The studies could be divided into three groups, according to their use of theory. First, a group of studies using a predetermined concept or theoretical perspective to understand and describe different aspects of shift reports, for example, a "socio-technical perspective" on shift reports (Kerr 2002), shift reports as "rituals" reducing anxiety and/or maintaining social order (Ekman & Segesten 1995, Evans *et al.* 2008), creations of "collective narratives" at shift reports (Parker *et al.* 1992). The selection and use of externally given concepts to examine shift reports have yielded some thought-provoking insights, but they also raise questions about the credibility of the choice of concepts and, consequently, of the conclusions drawn. Second, a group of studies drawing comprehensively on social science methodology, such as grounded theory, critical ethnography, conversation analysis, etc. Third, a group of descriptive studies in which theory was not used to explain the development of thematic categories. The most recent studies belong to the second and third groups of studies and follow two different strands of inquiry: studies *of* health and studies *for* health respectively. However, as pointed out by Green and Thorogood (2014), doing applied research *for* healthcare does not legitimise under-theorised analyses.

DISCUSSION

Considered together, these 19 field studies of shift reports illuminated a set of processes that facilitated care, and formed up nursing teams. These processes were significant across a diverse range of nursing contexts, countries and specialist areas. The studies described shift

report practices in detail and identified several factors contributing to a marked social, organisational and material distribution of clinical knowledge. Shift report practices were described as highly conventionalised and locally situated, but with occasional opportunities for improvisation and negotiation. Furthermore, shift reports were described as multifunctional meetings with individual and social effects. These findings resonate with Hilligoss and Cohen's (2011) description of "hospital handoffs" as multifunctional situated routines, though their starting point of organisation theory and their emphasis on organisational routines does not capture the full range of communicational features identified in the present review.

Accurate and complete shift reports are regarded as crucial for patient safety and quality of care. However, Cohen *et al.* (2012) caution growing pressures to standardise "hospital handoff" procedures (see for instance the review by Arora *et al.* (2009)), because these standardised handoffs are based on misleadingly simple models of communication that fail to acknowledge the constitutive effects of shift report communication. A key, albeit implicit, assumption about standardised shift reports is that conversation is always just starting, in the sense that all the oncoming nurses are perceived to always have the same need for clinical knowledge in order to start working. The review's findings clearly indicated that nurses routinely customise and negotiate relevant clinical knowledge, according to their situated understanding of the clinical situation and the oncoming nurses' needs for clinical knowledge. In this context of flexible and economical language use, it seems unlikely that nurses would choose to embrace standardised routines for reporting. Moreover, Bangerter *et al.* (2011) suggested that informal conversation might enhance a system's resilience against error and, in some situations, be a more accurate mode of communication, compared to formal routinized communication. These constitutive effects of informal communication and the possible detrimental effects of structured procedures lead Cohen *et al.* (2012) to suggest training professionals in anticipating and examining the other participants' perspective at "hospital handoffs".

Our recent review of social science and linguistic text analyses of nurses' records (Buus & Hamilton 2016) indicated that these analyses were heavily theorised, with a strong emphasis on social regulation of patients. As recording and reporting are intrinsically related institutional practices, it was surprising that the studies of shift reports were generally under-

theorised and the issue of social regulation of patients completely absent. These differences may be related to the character of data. Records can be "collected" as the nurses' objective and objectifying categories detached from their messy everyday practices, whereas field research of shift reports "automatically" emphasises the situated negotiations taking place in everyday shift report practices. The effects of the institutional machinery seem more apparent in the documentary data, which led to a skewed use of theory.

In our definition of nurses' shift reports, we emphasised that it is a communication process taking place during a particular organisational occurrence. Like any meeting between professionals in health care organisations, it can be examined with a perspective derived from a variety of research traditions. As observed by Kitson et al. (2014), nurses' communication is under-researched and under-theorised, which may cause research on nurses' shift reports to appear non-cumulative and fragmented. Contrary to Kitson et al.'s (2014) suggestion about developing a more integrated approach to this area of research, we believe that more explicit attention should be given to theory and research methodology, in order to develop and deepen the field, to encompass more specific types of research and research purposes.

Limitations

As pointed out by Kitson et al. (2014), the qualitative research on nurses' shift reports is characterised by varied terminology and varied research purposes, which makes it challenging to compare analyses. Being true to the intrinsic diversity in qualitative descriptive research, we tried to counter this challenge, by delimiting the review to include only qualitative field studies of shift reports and by focusing on the production of clinical knowledge, which homogenised the sample of studies and increased their comparability. Moreover, the decision only to include English language journal articles of nurses' shift reports excluded journal papers and monographs that only touched on the topic, such as information behaviour, knowledge construction, ward culture, etc. Although such neighbouring issues could be highly relevant for understanding nurses' shift reports, we believe that the inclusion of such issues would have a negative effect on the studies' comparability. We could have reduced the sample of studies further by excluding studies on the basis of their contribution to the field of research and/or methodological quality, but we decided to review the most comprehensive sample of methodologically comparable studies.

On the basis of the systematic search for ancestry and decadency references and on our general knowledge of the field of research we are confident that we have included most relevant studies. The process of including and excluding papers was made on the basis of consensus judgements guided by explicit criteria. However, some borderline papers - typically deductive content analyses - gave rise to extensive discussions and other reviewers can potentially challenge the final judgements.

CONCLUSION

The early studies in the present review forwarded very convincing theoretical issues, such as the social functions taking place at shift reports and their basic stages, but they were founded on relatively little empirical evidence. Several subsequent studies have substantiated and further problematized some of these issues on the basis of extended datasets, for instance by underscoring negative effects of social norms for reporting. In a recent review of studies of nursing "handoffs", Staggers and Blaz (2013) suggest that our knowledge of implicit functions at shift reports and of shift reports as a ritual was saturated. We disagree about the former conclusion because these issues have still not been examined extensively on the basis of rich and contextualised datasets. Finally, as nurses' shift report is a meeting between professionals it is an obvious site to study the situated accomplishment of "professional nursing" the review provided situated details that are important in the present debates round the efficiency of clinical communication, standardisation of communication, and technologically mediated communication.

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Table 1. The Criteria For The Evaluation Of Qualitative Research Papers

1. Are the methods of the research appropriate to the nature of the question being asked?

2. Is the connection to an existing body of knowledge or theory clear?

Methods:

3. Are there clear accounts of the criteria used for the selection of subjects for study, and of the data collection and analysis?

4. Is the selection of cases or participants theoretically justified?

5. Does the sensitivity of the methods match the needs of the research questions?

6. Has the relationship between fieldworkers and subjects been considered, and is there evidence about the research was presented and explained to its subjects?

7. Was the data-collection and record keeping systematic?

Analysis:

8. Is reference made to accepted procedures for analysis?

9. How systematic is the analysis?

10. Is there adequate discussion of how themes, concepts and categories were derived from the data?

11. Is there adequate discussion of the evidence both for and against the researcher's arguments?

12. Have measures been taken to test the validity of the findings?

13. Have any steps been taken to see whether the analysis would be comprehensible to the participants, if this is possible and relevant?

Presentation:

14. Is the research clearly contextualised?

15. Are the data presented systematically?

16. Is a clear distinction made between the data and its interpretation?

17. Is sufficient of the original evidence presented to satisfy the reader of the relationship between

the evidence and the conclusions?

18. Is the author's own position clearly stated?

19. Are the results credible and appropriate?

Ethics:

20. Have ethical issues been adequately considered?

Study:	Aim:	Conceptual framework(s):	Setting:	Data collection methods and data:	Analysis:	Key findings and interpretations:
Parker et al. 1992	To examine shift report practice	None reported	6 surgical and medical wards in Australia	Observation of 12 shift reports	No methods reported	The handover is described as a collective narrative. As a working community, the nurses communicate clinical information, demonstrate professional competence, and seek group validation
Ekman and Segesten 1995	To explore the ritual and content of oral shift reports	Anthropological ritual theory	A internal medicine ward in Sweden	10 oral shift reports were observed and audio-recorded during a 1-month period and written records of brief conversations with nurses before and after the reports	A thematic analysis with four phases	The shift report is interpreted as a rite of passage. The nurses' ritual mediates medical power and authority and it transfers delegated rights and responsibilities from one nurse to another
Parker 1996	To examine shift report practice	None reported	Wards of different specialities in Australia	Observation and audio-recording	No methods reported	Shift reports were divided into four types according to who was giving/receiving the shift report and six dimensions of the shift report content were identified
Strange 1996	To identify the features and functions of shift report practices	Anthropological ritual theory	A critical care ward in UK	Participant observation. Type and scope of data are not reported	No methods reported	Ritual is found to serve valuable psychological, social and protective functions for its unwitting participants
Lally 1999	To what extent does the shift reports involve social cohesion of the group/team?	Symbolic interactionism	A surgical ward in UK	Participant observation and audio-recordings of 6 shift reports on two different days	Thematic analysis	5 categories integrated in a one-way model of nurses' communication: 1. The process of nursing, 2. Learning the ropes, 3. Them and us, 4. Model in action, and 5. Foreword and appendices
Hardey et al. 2000, Payne	To examine the nature and role of clinical	Ethnography	Five acute elderly care	Non-participant observation, 34 semi-structured	Grounded theory	Handovers were formulaic, partial, cryptic, given at high speed, used abbreviations and

et al. 2000	discourses used by nurses in their delivery of care to patients		wards in UK	interviews, audio-recordings of 23 handovers and documentary data: Kardex, care plans, ward diary and 'scraps'		jargon, required socialized knowledge to interpret, prioritized biomedical accounts and emphasized physical aspects of care (Payne et al. 2000) Scraps written during shift reports represent a strategy used to create a space in which to define and organize nursing knowledge (Hardey et al. 2000)
Manias and Street 2000	To examine the practices used by nurses in communicating with other nurses during shift reports	Critical ethnography	A critical care ward in Australia	Professional journaling, participant observation and individual and focus group interviews	Text analysis focusing on the exercise of power, examination and communicative practices during shift reports	Five major practices influence on shift reports: "the global nursing handover" and "the examination" are practices of handing over. "The tyranny of tidiness", "the tyranny of busyness", and "the sense of finality" are practices creating local norms for nursing care, which influence on the shift reports
Kerr 2002	To gain a better understanding of handover practices and functions and their implications for effectiveness	A socio-technical perspective	Two paediatric wards, a medical and a surgical ward, in UK	20 shift reports were observed and audio-recorded by a field worker who also performed follow-up interviews	A case study classifying shift report practices and functions according to nurses' roles, communication and technology	Shift report is as a complex communication event with a range of socially and technologically distributed practices and multiple functions (informational, social, organizational, and educational). These elements can conflict because of diverse participant needs and other demands
Grosjean 2004	To determine what triggers different types of structuring in multi-participant talk	Conversation analysis	Three hospital wards, a surgical, a medical and a paediatric ward,	Audio-recording and observation (details about data collection and dataset are not reported in English)	Conversation analysis	Multi-speaker configurations were linked to the participants' activities, professional and social status, distributions of knowledge, the physical setup of the site, configurations of written materials, and finally to 'local

			in France			norms', i.e. tacit, ingrained, 'ritual'-like, group habits providing orientational frameworks for local interaction
Buus 2006	To identify how shift reports influences the amount and content of the clinical knowledge produced among the nursing staff members	Ethnomethodology and conversation analysis	Two mental health wards in Denmark	Audio recordings of 2 x 3 consecutive shift reports, written records and field notes from one year's fieldwork at the wards	Applied conversation analysis	There were linguistic and social conventions for handing over clinical knowledge. Handing over caused a silencing of the least powerful nurses' voices, generated uncertainty, and promoted knowledge about the patients' clinical situation that was not necessarily precise or up-to-date
Engesmo and Tjora 2006	To explore the challenges of substituting face-to-face shift reports with asynchronous communication enabled by patient recording systems	Symbolic interactionism	Two wards (rheumatologic and surgical) in Norway	10 semi-structured interviews, participant observation and documentary data: emails, and documents, such as minutes	Comparative thematic analysis	Replacing face-to-face communication with extended employment of patient recording systems may hinder the practical accomplishment of nursing handovers. When nurses reported face to face, the content was customised according to immediate needs, ensuring the communication of important and pertinent information to the next nurse
Evans et al. 2008	To identify discourses of anxiety in nursing practice and to consider how anxiety might function as an organising principle in shift reports practices	Psychoanalytic theory	A medical ward in Australia	Observation of 14 shift reports	Text analysis	The important implicit function of the handover ritual is to keep anxiety at bay, thereby enabling the nurse to commence practice rather than being immobilised by the effect of potentially overwhelming anxiety caused by prohibited feelings of love and hate towards the patient
Staggers and Jennings 2009	To describe the content and context of shift	None reported	7 acute care wards, medical	Audio-recording and observation of 53 patient	Content analysis	The content analysis identified 4 themes in the audio recordings. Observations exposed

	reports and explore whether nurses use computerized support		and surgical, in USA	reports involving 38 nurses, including field notes		informal and unstructured reports with heavy reliance upon nurses' memory, as well as high noise levels and interruptions
Bangerter et al. 2011	To contribute to a better understanding of conversation in shift reports and use of direct reported speech in storytelling in institutional contexts	Conversation analysis	A surgery ward and a rehabilitation ward in Switzerland	Video-recording of 30 (out of 40 consecutive) shift reports during a 5 day period on both wards (15 video-recordings from the surgical ward were not transcribed in detail for conversation analysis)	A quantitative content analysis and a qualitative conversation analysis	Storytelling is a recurrent practice of nurses accomplishing their everyday professional business in shift reports. Self-quotes seem to account for the speaker's professional rationality. Direct quotes of other nurses seem to be used as public displays of the legitimacy of one's own actions or decisions. Direct quotes of patients are instrumental in complaint stories
Staggers et al. 2011	To examine nurses' use of patient summary reports in an electronic health record at shift reports	None reported	The study was conducted in two different institutions, 3 surgical and 2 medical wards, in USA	93 shift reports were audio recorded, observation of shift reports was initiated 30 minutes before end of shift (one observer focused on the context of report, another on the use of computers), and follow-up interviews with the reporting nurses	Content analysis	The computerized patient summary report and the electronic health record were minimally used during the shift report and the existing patient summary reports did not provide adequate cognitive support for nurses. The patient summary reports were incomplete, rigid and did not offer "at a glance" information, or help nurses encode information (through writing)
Liu et al. 2012	To examine communication and power relations surrounding medication communication at shift	Critical ethnography	Two medical wards in Australia	290 hours of participant observation, 72 field interviews, 34 hours of video-recordings, 5 reflective focus groups	Fairclough's critical discourse analysis	Nurse coordinators' group shift reports in private spaces prioritized organisational and biomedical discourses. There was little evidence of the nursing voice during group shift reports to dispute structural hierarchies and medical dominance

	reports					
Johnson et al. 2012	To explore content and structure of the information conveyed at shift reports	None reported	Predominantly medical surgical clinical settings in Australia	81 shift reports were audio recorded	Thematic analysis	Five major themes of information: 1. Identification of the patient, 2. Clinical history/presentation, 3. Clinical status, 4. Care plan, and 5. Outcomes or goals of care.
Sarvestani et al. 2014	To explore challenges of shift report practices	None reported	Three paediatric wards in Iran	Observation, audio-recording of 14 handovers and nine in-depth interviews with nurses	Inductive and summative content analysis	Two overall themes were identified. First, the shift reports were unstructured and non-holistic. Nurses were prejudice and uninvolved in the shift reports. Second, the shift report were poorly managed in terms of tasks, time and location

Table 1. Abbreviated data extracted from the systematic evaluations