Coventry
University

# Understanding best practice within nurse intershift handover: what suits palliative care?

Kerry Messam, Annie Pettifer


## Abstract

Following identification of the limitation of nurse intershift handover within a specialist palliative care unit, a review of the research literature is undertaken. The aim is to identify and appraise what is known about best practice within nurse intershift handover and evaluate the implications for practice within a specialist palliative care inpatient unit. The retrieval of literature identified 19 pertinent research papers which were critically analyzed. Three main themes emerged within the literature: purpose; type; and content of handover. Only two studies had been carried out within a generalist palliative care context; however, five sub-categories emerged that may be significant in meeting the demands of specialist palliative nursing. These were: clinical decision-making; staff support; maintaining confidentiality while handling sensitive information; patient involvement; and type of information exchange. All themes are presented within this article. The literature review suggests that traditional verbal nursing handover may be the most advantageous handover method within inpatient specialist palliative care, though attention to structure and focus is vital.


**Key words:** Clinical decision-making ● Communication ● Intershift handover ● Specialist palliative care nursing

**Kerry Messam** is Macmillan Palliative Care Nurse Specialist, Northampton General Hospital NHS Trust, Northampton Centre for Oncology, Northampton, and **Annie Pettifer** is Senior Lecturer in Adult Nursing, Coventry University, Department of Nursing, Midwifery and Health Care, Coventry, England, United Kingdom

*Correspondence to:*
***Kerry Messam***
Email: kerry.messam@ngh.nhs.uk

Within any inpatient healthcare setting where patients require continuous nursing care, delivery of such care is reliant upon a series of nursing teams working in shifts throughout the 24-hour period. Nurse intershift handover has become the traditional and dominant form of communication between nurses caring for patients on one shift to the next (Cahill, 1998). The aim is to exchange information from the outgoing to the incoming nurses to expatiate effective nursing care across the shift time spans.

A substantial body of nursing research and audit literature appraising nurse intershift handover has evolved and the necessity of such handover seems undisputed. Lally (1999), Kerr (2002) and Hoban (2003) concur that intershift handover plays a pivotal role in enabling the nurse to exchange information to deliver consistent patient care. The literature identifies four main types of nurse intershift handover: bedside, verbal, taped and nonverbal (see *Table 1*).

Despite such primacy, there is little consensus of what might constitute good handover practice within the nursing literature, and the impact of the various handover methods on nursing care remains unclear (Cahill, 1998; Lally, 1999; Kerr, 2002). Researchers have considered intershift handover across a number of nursing inpatient contexts, including accident and emergency, medical, surgical, elderly and mental health environments (Lamond, 2000; Timonen and Sihvenen, 2000; Payne et al, 2000; Dowding, 2001; Bourne, 2000; Currie, 2002). However, consideration of handover within a palliative care inpatient context is limited and only two papers consider the needs of palliative care in a generalist setting (Kelly, 1999; Hopkinson, 2002).

The World Health Organisation (2002) defines palliative care as 'the active holistic care of patients with advanced, progressive illness'. Specialist palliative care inpatient services aim to manage the physical symptoms and offer psychological and spiritual support to those facing advancing disease. This includes end-of-life care with particularly complex needs which cannot be appropriately met within generic or less intense specialist services (National Institute of Health and Clinical Excellence [NICE], 2004).

Such inpatient facilities offer 24-hour nursing care and, in common with all such inpatient facilities, nurse intershift handover is considered pivotal to a consistent care provision. Palliative nursing is characterized by particular principles which underpin the care offered. These include multidisciplinary teamwork, holistic care, care of the family and others who are significant in patients' lives, and dealing sensitively with difficult dilemmas at the end of life (Lindop et al, 1997). It would seem likely the particular nature of the specialty may bring specific requirements on handover.

## Background

This literature review was prompted by a growing concern within a specialist palliative care

inpatient unit (SPCIPU), the former work place of the lead author (KM), that the verbal handover system was inefficient in a number of ways. While not formally evaluated, it appeared that the handovers were repetitive as a number of nurses commenced shifts at different times of the day necessitating repeated handovers from those already familiar with the care.

The need for repeated handovers was exacerbated by the range of skill level of oncoming nurses, which spanned healthcare assistants, registered general nurses (RGNs), bank and agency nurses. These nurses needed different types of information and delivering it appropriately meant further repetitions. Handovers often appeared unstructured and unfocused. There was neither informal agreement nor formal guidance as to what information should be included or excluded, so the content of the handover varied between those delivering it. This often ranged beyond patient care to the emotional needs of nurses or the organizational needs of the service.

Thus, it became apparent that the system of handover in use would benefit from some reviewing and adapting to suit the particular needs of specialist palliative inpatient nursing.

A review of the research literature on nurse intershift handover was therefore undertaken. It aimed to explore what is known within the research literature about the type of handover that would best suit the demands of the inpatient palliative care service. Key objectives were to consider what if any knowledge was available within the research literature that might address the following questions: what is the appropriate primary focus of handover on a SPCIPU? Which type of handover best meets the needs of the patients and staff within the unit? What is the appropriate content of handover to meet the purpose? This literature review served a dual purpose of meeting the academic demands of the lead authors' (KM) study for a BSc in Specialist Practice and limited the author to a literature review rather than conducting a research study.

The purpose of a literature review is defined by Hart (2001 p2) 'as an essential part of every research project'. The review was undertaken to meet the needs of one single SPCIPU only and no claims of generalization are made.

## Method

Medline, CINAHL and British Nursing Index were searched for relevant research literature. The following search terms were enlisted: 'reports'; 'shift report'; 'nurse handover'; 'inter-shift report'; 'palliative care'; 'specialist palliative care'; 'hospice'; 'verbal and non-verbal handover'; 'audiotaped handover'; 'communication'; 'multidisciplinary team'. Articles retrieved were limited to those published in English and within the last 10 years.

The literature review identified three reports (Currie, 2000; Bourne, 2000; Currie, 2002) that had been implemented within surrounding NHS Trusts, and attempts were made to collect grey literature but proved unproductive. Internet searches of the following websites were conducted to identify definition, and the principles of palliative care: National Institute of Health and Clinical Excellence and National Council for Hospice and Specialist Palliative Care Services.

Nineteen studies were retrieved between 1997 and 2007. Pertinent information from each article was analyzed by summarizing the following: date, author, background, type of study, method, results, analysis, discussion/recommendations and key themes. The intershift nurse handover literature considers the subject within the three themes of purpose, type and appropriate contents. Within this categorization, a number of sub-themes emerged (see *Figure 1*).

**Table 1. Type of handover**

**Bedside**
Located at patient's bedside, promotes patient and nurse face-to-face introduction and encourages patients' verbal participation in their care and handover process. This allows the nurse responsible for a group of patients to handover to the next nurse on duty (Greaves, 1999)

**Verbal**
Within an office setting, the nurse responsible for a group of patients exchanges relevant documented information with the oncoming shift of nurses (Lally, 1999; Bourne, 2000)

**Taped**
A one-way process of information exchange. The nurse in charge collects the relevant information and records this onto an audiotape so that the oncoming shift can listen at a convenient time and plan care (Dowding, 2001)

**Non-verbal**
As a new shift starts, nursing staff are responsible for reading over each individual patient's plan of care to allow them to plan and prioritize their workload (Taylor, 2002)

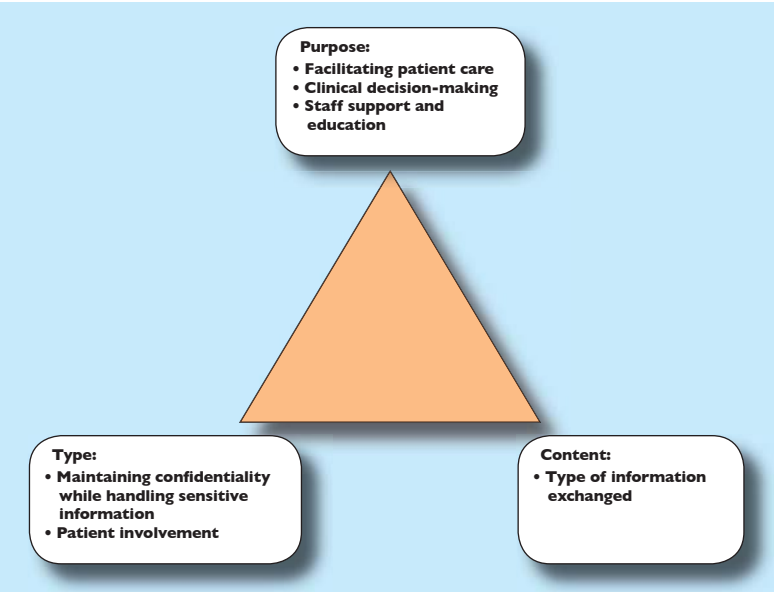
## Purpose of handover

In addition to facilitating the transfer of patient care from outgoing to incoming nurses, the purposes of clinical decision-making, staff support and education emerged from the literature as being of particular relevance for intershift handover within an inpatient palliative care setting.

### *Clinical decision-making*

Three papers considered the potential use of handover by nurses in structuring and processing

*Figure 1. Emerging themes.*




information about patients' condition which could usefully guide the care given during the subsequent shift (Kelly, 1999; Hardey et al, 2000; Lamond, 2000). These papers draw on ethnographic (Kelly, 1999; Hardey et al, 2000) and sociological (Lamond, 2000) theories to explore the processing of information to frame future care planning during handover.

Within two district general hospitals, Lamond (2000) drew comparison between the types and quality of information shared during nurse intershift handover. Information was exchanged verbally and within corresponding nursing and medical documentation. She found that 'global judgements' concerning patients' overall condition and psychological state were more commonly verbalized than recorded. These judgements may serve as summarizing signposts directing future care and also statements representing information processing by the offgoing nurse to direct the information processing of the ongoing nurse.

In his ethnographical account of bedside handover within a coronary care unit, Kelly (1999) found a similar process occurring. Utterances, such as 'so he has basically deteriorated over the weekend' and 'he's just really TLC [tender loving care]', framed the information handed over in such a way that the processing of their meaning has been achieved and then shared. Without being challenged from the oncoming nurse, shared understanding of the overall aims of care is shared and considered agreed across the nursing team.

Hardey et al's (2000) ethnographic study of 23 handovers analyzed the 'scraps' of paper commonly created by nurses during office-based handover. Such scraps are designed to be used exclusively by the nurses who have created them; many nurses used elaborate shorthand and often record evaluative, emotional or intuitive personalized statements which are not considered recordable in generally accessible documents. The authors suggest that such scraps are private spaces in with nurses individually process nursing information and construct their knowledge about patients.

This small body of literature suggests that handover has an implicit clinical function of formulating and then sharing such judgements across the nursing team whether that is individually, or in pairs (as in beside handover), or within a whole team within office-based handover. The recognition and facilitation of this function may be particularly relevant for palliative care nursing as there is an ongoing need for construction and reconstruction of team understanding of the goals of care as patients' condition deteriorates; to ignore this dimension may not serve nurses.

## *Staff support and education*

Staff support is acknowledged within the literature as an implicit function of nurse intershift handover, and vital to ensure the wellbeing of nursing staff (Cahill, 1998; Lally, 1999; Bourne, 2000; Payne et al, 2000; O'Connell and Penney, 2001; Hopkinson, 2002). It is apparent that each mode of handover facilitates different levels of staff support or in some cases, such as taped, no opportunity at all.

Verbal nurse intershift handover is emphasized within the literature as the most effective at facilitating the supportive needs of nursing staff during information exchange (Lally, 1999). Within Cahill's (1998) grounded-theory study, she questions the extent to which nurses' feelings can be expressed at the patient's bedside. In particular, she considers the practicalities of such practice, e.g. confidentiality and time constraints.

Hopkinson (2002) carried out a phenomenological study involving 28 RGNs on acute medical wards. Through semi-structured interviews, she explored the subject's perception of challenges and coping strategies used when caring for dying patients. Results found that verbal nurse intershift handover promoted team building, enabled staff to debrief, and acknowledged anxieties when caring for dying patients. However, the small sample employed questions the reliability used to discuss such issues. Hopkinson (2002) acknowledges that as a result of the anecdotal evidence regarding staff support, further research is

needed to evaluate the impact on patient outcomes.

Davidson (2000) substantiates that emotional support is paramount within the specialist palliative care field due to the emotional demands inherent within the specialty. If nursing staff are to be protected from professional burnout, morale must be maintained. Therefore, it would appear that the ability of nurses to gain team support during handover would be essential.

However, while recognizing the importance of handover for patient care, Bourne (2000) purports that supportive activity, such as education, team building and supervision, should be sought away from clinical practice. This then facilitates the focus on patient-centered care, reflecting the real purpose of handover (Bourne 2000). Gerrish (2001) argues that although there is provision for support mechanisms through clinical supervision in practice, they are poorly attended due to time constraints.

Staff support is undoubtly important, especially within a SPCIPU, but the authors question when and where this support should take place. Although handover seems a good opportunity to provide support, this appears to detract from the exchange of patient information. It remains unclear how staff support impacts on clinical practice and patient outcomes. Yet, if staff support were removed from handover, further time would need to be allocated to the provision of other support mechanisms, e.g. clinical supervision, reflective practice, counselling.

## Appropriate content of handover

Nine reports (Lally, 1999; Kennedy, 1999; Bourne, 2000; Dowding, 2001; Currie, 2002; Hoban, 2003; Malestic, 2003; Sexton et al, 2004; Clemow, 2006) within the literature retrieved discuss the optimal content of intershift handover. How it best facilitates nursing care in the subsequent shift has been a major focus of the research. However, these studies explore handover within a variety of clinical settings other than palliative care, and offer little consistency in their findings.

Kennedy (1999) suggests that the content of information exchanged needs to be pitched at a level acceptable to all grades of nursing staff. How the information is received depends upon individual levels of knowledge, understanding and attitudes. However, pitching information at an appropriate level for qualified and unqualified staff can be difficult to achieve in practice without further explanation, often leading to informal education and discussion.

In Currie's (2002) study and Malestic's (2003) anecdotal report, they assert the need to identify the optimal content of information exchange. Succinct information regarding six key areas arose from Currie's (2002) audit, including the reason for admission, treatment received, patient name and age, plans of care, and patients' medical history.

The clinical environment should guide the identification of information exchange, thereby increasing accuracy and the delivery of quality nursing care (Bourne, 2000; Currie, 2002). Indeed, within the holistic nature of specialist palliative care, it would seem appropriate that key areas of information exchange could be physical, social, psychological and spiritual.

Interestingly, a study by Dowding (2001) considered the content of information exchanged, the way it was processed and the effect on patient care. The author identified that 50% of information exchanged was unimportant. With the content of information significantly affecting the nurses' ability to plan care, results concluded that retrospective information was more meaningful than prospective information.

Clemow (2006) conducted several audits of handover and the implementation of a 'reduction strategy' to aid the process of information exchange that resulted in effective documentation and a more analytical approach to evaluating care. Sexton et al (2004) also examined the content of handover and found that a high proportion of information exchanged already existed in other documents and only 5.9% of information was not held in an additional source.

In agreement, Hoban (2003) suggests that the duplication of patient information should be minimized wherever possible. Basic patient information has often been unnecessarily documented within patients' plans of care. To promote accuracy and reduce duplication, Currie (2002) suggests the implementation of a framework using an acronym identifies key areas of information exchange. Indeed, it would seem appropriate that further consideration is given to the implementation of tools to guide the content of nurse intershift handover and the priorities within palliative care.

*'The duplication of patient information should be minimized wherever possible'*

## Type of nurse intershift handover

### *Maintaining confidentiality while handing over sensitive information*

The need for maintaining confidentiality within handover in palliative care is alike any other care setting. Nurses need to be aware and acknowledge any infringement on patients' personal space, and identify factors that could contribute to breaching confidentiality (Erlen, 1998). However, within a palliative care setting, patients whose current and future health status

*'Information may be exchanged during handover that has not yet been discussed with the patient'*

is sensitive and perhaps unacknowledged by them or within families are likely to be prevalent. As it is likely to be commonplace, intershift handover of these emotionally sensitive areas, such as what the patient understands of their future or patient's psychological needs, may need careful consideration.

All information exchanged during bedside, verbal, taped and non-verbal nurse intershift handover should be treated as confidential (Erlen, 1998). However, within the literature, the need for confidentiality and the risk of breaking it is mainly identified within reports concerning the exchange of patient information during bedside nurse intershift handover (Erlen, 1998; Greaves, 1999; Kennedy, 1999; Webster, 1999; Hopkinson, 2002).

For example, information may be exchanged during handover that has not yet been discussed with the patient, e.g. scan results. To avoid this risk, it would appear nurses go into private spaces to handover sensitive material (Hopkinson, 2002). Given the likely volume of this in an inpatient palliative care unit, bedside handover seems impractical. The research literature has not explored the implications of handing over aspects of nursing in which sensitive information may be integral to symptom management, e.g. emotional issues contributing to pain; however, it would seem that this may detract from palliative care practice to treat symptoms holistically.

Palliative care philosophy also espouses care of relatives and significant friendships within and before bereavement (NICE, 2004). While Timonen and Sihvenen (2000) suggest that nurses perceive bedside handover as an opportunity to involve relatives in care, about two thirds of patients did not want relatives to be involved in nursing handover and in practice their presence was minimal. Webster (1999) suggests that bedside handover has positively impacted on the care of relatives within the ward but does not explain the manner of this change in any detail.

Although it would appear that bedside handover may be useful in promoting patient-centred care, there are disadvantages of using it within the palliative care setting which may render it unsuitable due to the constraints of the need to discuss particularly sensitive information.

### *Patient involvement in nursing handover*

Analysis of palliative care philosophy reveals a strong commitment to patient-centred care within the specialty. Nurses are encouraged to involve patients, and that their wishes are paramount at all levels of decision making and care giving. However, the possible burden that this may place on severely sick, possibly exhausted patients, is documented (Thorensen, 2003).

A number of papers, principally those evaluating the practice of bedside handover, have explored the notion of patient involvement in handover (Cahill, 1998; Webster, 1999; Timonene and Sihvinen, 2000). When evaluating implementation of handover on his medical ward, Webster (1999) considered that the change had increased nurse-patient interaction and thus was in concordance with the team's philosophy of patient-centred care. However, Timonene and Sihvonen's (2000) comparison of nurses and surgical patients' perspectives of bedside handover found that patients were not as actively involved in handover as nurses thought. Patients found participation was hampered by tiredness – a similar result to that within Cahill's study (1998).

Cahill (1998) points out that patient involvement in handover does not always equal patient-centred care. Several patients did not wish to participate and, as Thorensen discusses (2003), were clearly at risk of encouragement to do so. It would appear that this is likely to be the case in patients who are traumatized and have poor physical status. Given the level of exhaustion prevalent in inpatients within palliative care units, it would seem that bedside handovers may be burdensome.

## Evaluation

This article aimed to review the research literature on intershift nurse handover within the inpatient care setting. Key objectives were to consider the appropriate primary focus of handover on a specialist palliative care unit, the type of handover that best meets the needs of its patients and staff, and whether the content of handover is appropriate to meet the purpose.

Despite a dearth of literature focusing on handover in palliative care, a number of pertinent themes emerged from the literature on handover. Although conducted within other inpatient settings, the themes provide useful insights when considering appropriate handover in palliative care. Considering the nature of this specialty, it is likely that particular demands are placed on the inpatient specialist palliative nurse which, in turn, impacts on nurse intershift handover, thus constraining and framing its explicit and tacit purpose, type and content.

The primary purpose of nurse intershift handover is clearly the exchange of information from the outgoing nurses to the incoming nurses to enable the latter to nurse appropriately. However, the literature demonstrates that handover serves a supportive function for nurses

in an inpatient setting. Given the well-documented emotional demands on staff working with palliative care patients, it would seem unsurprising if handover time is used for staff nursing support rather than more patient-centred functions. It may be that this would decrease if other supportive mechanisms are available, but this has not been evaluated within the research literature.

Furthermore, the literature indicates that handover is used by oncoming nurses to assimilate information about individual patients to guide future care. Although this subject is largely explored in non-palliative specialist settings, it does appear that it is relevant for framing and sharing the appropriate goals of care as they change while a patient deteriorates.

With regard to the most appropriate type of handover within a specialist palliative inpatient setting, there are limitations when using the bedside for handing over nursing information. While the generalist setting appears to increase patient involvement in their nurse care planning, this potential benefit is limited for debilitated patients who may be too exhausted to actively participate or have other priorities for their limited energy. Given the high levels of fatigue in palliative patients, it would seem bedside handover should be used with caution. Furthermore, bedside handover within a shared area has a propensity to unwittingly disclose confidential information to both relatives and other patients. Handover of sensitive information is also highly problematic. The supportive function of handover could be eroded by the use of taped handover. However, if staff are supported effectively through other mechanisms within the specialist unit, such as clinical supervision, reflective practice and counselling availability, handover may become more focused and taped handover may become appropriate.

Given the complexity of palliative patients needs and the holistic nature of palliative nursing, the scope of legitimate nursing information - which may need to be passed form outgoing nurses to incoming shift nurses - is considerable. Insights from the literature include the need for structured guidance covering key aspects of current care and the development of a plan for future care.

## Conclusion

The issues of developing a more appropriate nurse intershift handover strategy require urgent attention in all specialties. As O'Connell and Penny (2001) purport, any nurse intershift handover that is ineffective in practice results in loss of time and valuable resources. The authors recommend that practitioners and managers must consider nurse intershift handover as an essential and complex component of nursing practice and not leave it to ritualistic habit. If this is to be realized, it is vital that practitioners and managers carefully consider the relationship between how ward nursing is structured, the experience that patients have, and design systems which can best meet the particular needs of patients. Clearly, one system of handover will not be applicable in all settings.

Following review of the limited research available of intershift nursing handover, it would appear that design of verbal, office-based nursing handover is the most advantageous for a specialist palliative care inpatient setting. Certainly, this form will provide some staff support, enable nurses to process information, maintain confidentiality and handover sensitive aspects of care. However, the literature suggests it could be more effective with guidance to structure its content as long as this guidance does not stifle nurses' ability to assimilate and share information informally. Further research is needed to develop and evaluate a structure which can ensure vital information is transferred and assimilated within a palliative care inpatient setting. Currie's work (2002) may provide a sound basis for this.

If sufficient alternative supportive mechanisms are in place, taped handover may well serve the patient's needs. Bedside handover is problematic in the specialist palliative care setting due to levels of patient fatigue and the need to handover sensitive and confidential information. However, due to its ability to involve patients, it may be appropriate for some patients at some point during their inpatient stay. IJPN

*'The supportive function of handover could be eroded by the use of taped handover'*


Bourne C (2000) Inter-shift report: a standard for handovers. *Nursing Times Research* **5**(6): 451–9

Cahill J (1998) Patient's perceptions of bedside handover. *J Clin Nurs* **7**(4): 351–9

Clemow R (2006) Care plans as the main focus of nursing handover: information exchange model. *J Clin Nurs* **15**(11): 1463–5

Currie J (2000) Audit of nursing handover. *Nurs Times* **96**(42): 44

Currie J (2002) Improving the efficiency of patient handover. *Emerg Nurse* **10**(3): 24–8

Davidson R (2000) Stress issues in palliative care: caring for the community professional. In: Cooper J (ed). *Stepping into Palliative Care – A Handbook for Community Professionals*. Radcliffe Medical Press, Oxon: 197–206

Dowding D (2001) Examining the effects that manipulating information given in the change of shift report has on nurses' care planning ability. *J Adv Nurs* **3**(6): 836–46

Erlen J (1998) The inadvertent breach of confidentiality. *Orthop Nurs* **17**(2): 47–50

Gerrish K (2001) Moving towards clinically effective care: identifying and overcoming barriers. *Klinisk Sygepleje* **15**(1): 11–8

Greaves C (1999) Patients' perceptions of bedside handover. *Nurs Stand* **14**(12): 32–6

Hart C (2001) *Doing a Literature Search*. Sage Publications, London

Hardey M, Payne S, Coleman P (2000) 'Scraps': hidden nursing information and its influence on the delivery of care. *J Adv Nurs* **32**(1): 208–14

Hoban V (2003) How to … handle a handover. *Nurs Times* **99**(9): 54–5

Hopkinson J (2002) The hidden benefit: the supportive function of nursing handover for qualified nurses caring for dying people in hospital. *J Clin Nurs* **11**(2): 168–75

Kelly R (1999) Goings-on in a CCU: an ethnomethodological account of things that go on in a routine hand-over. *Nurs Crit Care* **4**(2): 85–91

Kennedy J (1999) An evaluation of non-verbal handover. *Prof Nurse* **14**(6): 391–4

Kerr M (2002) A qualitative study of shift handover practice and function from a socio-technical perspective. *J Adv Nurs* **37**(2): 125–34

Lally S (1999) An investigation into the functions of nurses' communications at the inter-shift handover. *J Nurs Manag* **7**(1): 29–36

Lamond D (2000) The information content of the nurse change of shift report: a comparative study. *J Adv Nurs* **32**(4): 794–804

Lindop E, Beach R, Read S (1997) A composite model of palliative care for the UK. *International Journal of Palliative Medicine* **3**(5): 287–92

Malestic S (2003) A quick guide to verbal reports. *RN* **66**(2): 47–9

National Institute of Health and Clinical Excellence (2004) *Guidance on Cancer Services Improving Supportive and Palliative Care for Adults with Cancer – The Manual*. NICE, London

O'Connell B, Penney W (2001) Challenging the handover ritual. Recommendations for research and practice. *Collegian* **8**(3): 14–8

Payne S, Hardey M, Coleman P (2000) Interactions between nurses during handovers in elderly care. *J Adv Nurs* **32**(2): 277–85

Sexton A, Chan C, Elliott M, Stuart J, Jayasuriya R, Crookes P (2004) Nursing handovers: do we really need them? *J Nurs Manag* **12**(1): 37–42

Thoresen L (2003) A reflection on Cicely Saunders' views on a good death through the philosophy of Charles Taylor. *Int J Palliat Nurs* **9**(1): 19–23

Taylor C (2002) Assessing patients' needs: does the same information guide expert and novice nurses? *Int Nurs Rev* **49**(1): 11–9

Timonen L, Sihvenen (2000) Patient participation in bedside reporting on surgical wards. *J Clin Nurs* **9**(4): 542–8

Webster J (1999) Practitioner-centred research: an evaluation of the implementation of the bedside handover. *J Adv Nurs* **30**(6): 1375–82

World Health Organisation (2002) WHO definition of palliative care. WHO, Geneva. Available at: www.who.int/cancer/palliative/definition/en/ (last accessed 14 April 2009)