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Approaches to Improving Nursing Handover in Surgical Wards Liaquat University Hospital Hyderabad

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ABSTRACT

Background: Effective nursing handover plays a vital role in maintaining patient safety and ensuring continuity of care, especially in surgical wards, where patients often have complex medical needs. At Liaquat University Hospital (LUH) Hyderabad, handovers are often inconsistent and informal, which can lead to miscommunication, treatment delays, and negative patient outcomes. **Objective:** This study aimed to evaluate current nursing handover practices in the surgical wards at LUH Hyderabad, identify the main challenges faced by nurses, and explore practical strategies such as standardized formats and structured communication to improve the quality and safety of handovers. **Methods:** A descriptive cross-sectional study was carried out from February 10, 2025 to June 10, 2025, involving 90 nurses selected through purposive sampling. Data were gathered using a structured questionnaire divided into four sections: demographic details, current handover practices, challenges and quality of handovers, and suggestions for improvement. The data were analyzed using SPSS version 23 with descriptive statistics. **Results:** Of the 90 participants, most were staff nurses (53.3%) or nursing students (36.7%), and about one-third had 1–5 years of professional experience. The most common handover method combined verbal and written formats (44.4%), but only 40% used a structured tool like SBAR. Key obstacles included frequent interruptions (41.1%), time limitations (34.4%), and lack of proper training (34.4%). Just 41.1% of respondents felt that current practices effectively ensured patient safety. However, a large majority (81.1%) supported adopting SBAR, and popular suggestions for improvement included bedside handovers (33.3%) and the use of checklists (28.9%). **Conclusion:** The study revealed that nursing handovers at LUH Hyderabad are often unstructured, which compromises communication and patient safety. To address these gaps, there is a strong need for standardizing handovers through tools like SBAR, offering regular training, managing time more effectively, and improving the ward environment to support safer and more efficient communication.

INTRODUCTION

Nursing handover is very crucial to nursing practice for patient safety, which occurs among nurses during shifts changing for transferring professional responsibility and accountability. Handover is a regular process that mostly occurs two to three times a day in almost all hospitals {Yeti, 2021 #1}. In the hospital, during handover there is one of the most important aspect is communication among health professionals, that is defined as the sharing of information about the patient and the transfer of responsibility for the care about patients {Telles, 2020 #2}. In hospital departments providing 24-hour patient care requires Handovers between shifts. Handovers are the transfer of responsibility and information about the patient between health care providers. These are moments of potential risk to patient safety with possible side effects. In previous studies on patient safety and preventable adverse events, about 60% of events were associated with communication problems, particularly during transfers. Improving transfers has recently become a major goal for safer patient care. Transfers face various challenges, such as: Content quality, time constraints, high station variability and interruptions. Standardizing the transfer process, often using mnemonics, has improved the quality of the content. Bedside Handovers are another suggested approach to improving the transfer process, especially for patient safety Numerous issues are noted in the review, including a lack of standardization, poor communication, insufficient documentation, and incomplete handover. Handover refers to the transfer of patient data and

obligations between healthcare providers. It is a main feature of care coordination, especially when patients are switched between different clinical teams or levels of care. The handover procedure, however, is rife with difficulties that could result in medical blunders, service delays, and patient injury (Ali, A. Q. (2023). The delivery format in the 5 surgical wards of our hospital varies according to the time of day and the subsequent health care provider staffing. The services have specialties: Gynecology, general surgery 1,2,3 and 4 Surgical ICU, Neurological ICU and orthopedics. Each ward requires three or four nurses in the morning, two to three nurses in the afternoon with mid-afternoon Handovers in the afternoon, and one or two nurses during the night shift. The nurse assistant present throughout the 24-hour period also attends the Handovers. They help with many tasks at the bedside, but are not involved in drugs or tests such as blood tests or electrocardiograms. In our university hospital, up to 200 patients are treated in Gynecology, General Surgery (Units I–IV), Orthopedics, Surgical ICUs, Neurological ICU and approximately 200 patients are admitted in these wards, and nursing staff perform three shift-based handovers every 24 hours, totaling nearly 600 handovers per day. Despite the frequency and importance of these transitions, the quality and consistency of nursing handovers remain a concern. To explore current handover practices, perceptions, and potential gaps, a structured questionnaire was distributed and completed by 90 nurses working in the surgical wards of LUH. This study aims to identify existing challenges in the handover process and suggest evidence-based approaches for improvement. The duration of the transfer varies from 10 to 15 minutes per patient at afternoon time. The purpose of this study is to observe the current process of Handovers of nursing in general surgical wards and to examine approaches for improvement, particularly standardization, through quantitative analysis. The Handover is described as the transfer of responsibility for patient care from one provider or team of providers to another. The Handover is a routine forum for the communication of care during the change of position, during which nurses take breaks and follow patients in services {Cho, 2022 #27}. Clinical abandonment is a critical process in health care services where nurses are typically employed multiple times per working day, with the goal of facilitating the clinical transfer of the patient to facilitate patient-centered care. Clinical transfer is used by nurses to provide information on drug changes and how these changes relate to patient assessment parameters. As a result, ambiguity and incomplete communication during clinical delivery can increase the risk of adverse events. Ambiguities in clinical delivery include a lack of information sharing about critical components of patient care, such as vital signs, initial diagnosis, ongoing treatment, and new prescribed medications. Providing safe and adequate health care is extremely important for the health of patients. At present, a large number of safety issues have posed health problems and many personal and organizational strategies have been developed to promote patient safety. In the past, nurses provided patient information to new nurses to ensure continuity of care. Relevant information in team transfer often includes the diagnosis of the patient, the procedures performed, the hemodynamic stability, the treatment plan and all the topics of discussion during transitions between physicians. Over time, the practice of changing the shift of care per shift has changed. In most cases, the patient and his family were not present or part of the transfer practice. Most care is provided in a conference room or nursing unit, away from the patient's bed, in a process that does not allow the patient and family to actively participate in the exchange of information. By transferring the change to the patient's bedside, the incoming nurse can visualize the patient and ask questions of the previous caregiver and the patient. It encourages patients to actively participate in their care plans and implements standardized transfer communication between host families {Chien, 2024 #28}.

Rationale

Nursing handover plays a critical role in ensuring patient safety and the delivery of high-quality care, particularly in surgical wards where patients are in fragile condition and require continuous monitoring. At Liaquat University Hospital (LUH) Hyderabad—similar to many hospitals in developing countries ineffective and inconsistent handover practices have been observed, leading to communication breakdowns, missed treatments, medication errors, and compromised patient outcomes. Handover is the process of transferring responsibility for patient care from one nurse or shift to another. In surgical settings, where patients face multiple risks such as anesthesia effects, pain management challenges, and post-operative complications, the accuracy and completeness of handovers become even more vital. A poor handover can result in delayed interventions, overlooked complications, and duplication of tasks, thereby increasing the workload on nursing staff and jeopardizing patient safety. Despite the importance of structured handover, there is currently limited research on existing handover practices at LUH Hyderabad. Identifying these gaps is essential for introducing evidence-based strategies such as the SBAR (Situation, Background, Assessment, Recommendation) framework, which has been globally recognized for improving the quality and safety of clinical communication. Relevance to SDG 3 Good Health and Well-Being

This study contributes to improving health systems by enhancing the safety and continuity of patient care through better handover practices. Reducing preventable medical errors and improving communication among healthcare providers can significantly lower complication rates and improve patient outcomes. Relevance to SDG 4 Quality Education

The research highlights a lack of formal education and training among nurses regarding standardized handover techniques. By advocating for professional development and capacity-building initiatives, the study supports lifelong learning and skill enhancement, empowering nurses to perform more effectively in critical care situations.

Objectives

1. To assess nurses' satisfaction and confidence in the information received during handover.

2. To Find out the current practices used during nursing handover in surgical wards.
3. To analyze the relationship between staff experience and perceived handover quality
4. To determine the impact of structured handover tools (e.g., SBAR) on communication
5. To evaluate the adequacy of time allotted for giving and receiving handover.

LITERATURE REVIEW

This research is grounded in two key concepts: communication and patient safety. Communication is defined as an ongoing process of exchanging pertinent information, where messages are conveyed, received, and comprehended. Patient safety refers to minimizing the possibility of preventable harm linked with medical care to an acceptable level. When reviewing the literature on communication during handover and its association with patient safety, findings indicate that communication failures in handover arise primarily from the absence of uniformity and structure in the communication procedure. These issues are marked by information being shared partially, inaccurately, or not at all, leading to delays in diagnosis, treatment, and overall patient care. Additionally, several obstacles have been recognized that disrupt and adversely affect the communication process during handovers. These include language and knowledge differences between communicators, simultaneous conversations among staff in the departments, the length of the handover, lack of team involvement, use of mobile phones, and interruptions from personnel of other departments. These challenges hinder the effective exchange of patients' clinical status, further complicated by weak institutional cultural indicators related to organizational structure da Silva, P. C. C., et al. (2024). Ineffective communication at transition points is the leading cause of catastrophic or sentinel events in hospitals. About 50% of the adverse events result from communication problems between health professionals. Given the potential risks associated with clinical transfer, many leading health organizations have identified it as a priority area for improvement Earlier clinical surveys were based mainly on the perspectives of physicians or nurses. However, to achieve high-quality clinical transfers, communication and collaboration between different health professionals is often required. The purpose of this cross-sectional study was to examine the approaches to improve clinical Handovers of healthcare professionals. We examined their opinions on how clinical Handover works and what improvements are possible. In particular, I have sought the views of health professionals on the effectiveness of transfers. Participation of the patient and his family in the transfer of the bed to the patient bed; Confirmation of understanding, clarification of information and provision of information during clinical transfer; Role modeling behavior; Training needs of health professionals; Type and report adverse events and suggestions to improve the Handovers process. The lessons learned can help to better understand the ability of healthcare professionals to develop local improvements in the transfer of responsibilities. The study is also a valuable contribution to patient safety policies and standards in relation to clinical transfer practices Pilcher, L., et al. (2022). However, these work restrictions have had unintended consequences such as increased frequency of transfers, the introduction of night swimming systems, a changing mindset, and an increased risk of preventable adverse events related to physician coverage from another team. These included for the first time the transfer conditions. Although these requirements are referred to as "care transitions", most requirements relate to transfers. The main function of the clinical service is to ensure the communication between the caregivers regarding the information concerning the patient in order to guarantee the continuity of care. Other transfer functions include education, briefings and debriefings, team building, social interaction and networking. At the time of transfer, the sisters transfer the responsibility of the patient to other colleagues. A good exchange of information between caregivers is the basis for continuity of care and patient safety. It should also be noted that the clinical reference offers the opportunity to transmit information about the patient's condition. Clinical transfer of patients has been found to increase patient satisfaction by better informing patients, giving them more personal care, developing the relationship between patient and caregivers, and reducing patient discharge time by improving patient satisfaction patient education Ghosh, M., et al. (2025) Positive results were found in a patient survey. In this study, clinical transfer ensured patient safety, increased efficiency, and contributed to the development of teamwork and patient-centered care. On the other hand, {Chaica, 2024 #26} found in their studies that clinical transfer increased job satisfaction, interpersonal relationships and accountability, while helping to collect patient information and reduce the number of patient's overtime. The transfer of beds to hospitals is an important opportunity to develop communication between caregivers, patients and their loved ones. The World Health Organization focuses on communication during bedside transfer as a primary safety. However, there are many obstacles to effective and safe transfer, which can be detrimental to the patient and compromise his safety, such as poor communication, inadequate standardization and equipment problems, overloaded stations, poor planning, or the complexity and complexity of the cases high number of cases, lack of training, interruptions and fatigue. There are many clinical transfer studies that are one of the most important roles in nursing. However, in the absence of a clinical transfer study in Turkey, it is relevant for this study. In addition, it is important to determine how and how the caregivers transfer the patient, which is taken into account during the clinical transfer and what kind of problems occur during the procedure. The purpose of this study is therefore to determine the attitudes and attitudes of caregivers at the time of clinical presentation and to provide suggestions and advice to nurses in light of the results obtained. Previously, people believed that hospitals were safe places for medical treatments. In the early 1990s, the results of a study conducted by Harvard University in the United Kingdom raised initial concerns about patient safety Dumbala, G., et al. (2025). The results of this study showed that 98,000 patients had sustained serious injuries during the study due to medical errors. Fifty-five percent of these

patients recovered from injury a month later, 7% had long-term complications and 14% died. The important fact was that 69% of these errors could possibly be avoided. According to this study, a 1999 report by the Institute of Medicine greatly surprised health care providers and their clients. In this report, titled "The mistake is human: Building a safer health system," it is estimated that medical errors cause between 44,000 and 98,000 deaths in hospitals in the United States each year. These statistics have changed the public's attitude towards the safety of medical treatments and have spurred many political efforts in the United States to identify risk factors for medical errors and improve patient safety. Studies conducted by Joint Commission International (WHO Collaborating Center for Patient Safety Solutions) have shown that lack of communication of information is the major risk factor for 65% and the risk factor contextual for 90% of sentinel events. Disclosure occurs on a number of occasions among health service providers. One of the examples of communication of information in health facilities is during care instructions {McCusker, 2025 #29}. Effective transfer facilitates continuity of care and increases patient safety. Transfer is a common tradition among nurses; however, standard and effective skills in information transfer and communication of information are not formally taught during university education in nursing; On the contrary, nurses acquire these skills during their daily practice and train more experienced nurses. The main goal of Shift-Over is to provide patients with clinical information and to ensure safe and high-quality care. However, poor communication of information during non-standard and inefficient substation transfers can compromise patient safety. The results show that the inefficient transfer of posts increases the risk of medication errors and sentinel events, delays treatment, decreases patient satisfaction and increases the length of stay in hospital. The results of one study in pregnant women showed a significant correlation between the number of deliveries per shift and unplanned deliveries by caesarean section (Barfield, N. A. (2025). It was noted that poorly managed shift handover reports can cause delays in patient care by one to two hours. Thus, effective communication of patients' clinical information is a key factor in providing safe and high-quality care. Disclosure is so important that the US Security Committee stated that the standardization of the reporting process in the health system was the second national security objective. This objective focused on the communication of current and credible information that disrupts the shift process as little as possible Gungor, S. and B. Tosun (2025). In our country, Pakistan, reports on the transfer of work teams will usually be based on the oral, patient and not on an integrated protocol. However, the content of Kardex's does not necessarily reflect the patient's management priorities. The absence of an integrated transfer protocol in our country as well as the lack of international job transfer formats for our health facilities made it difficult to standardize positions. There are currently two types of accreditation standards for hospitals around the world, namely JCAHO (Joint Commission for Health Organization Accreditation Commission) and JCI (Joint Commission International). The JACHO and JCI standards have been developed for accreditation of health facilities in both developed and developing countries. In addition, the available transfer formats, such as SBAR, have been developed on the basis of developed country specifications and are therefore not applicable. CINAHL and Medline were looking for articles on care transfers. The search terms used were transfer, transfer, bedside, communication, report, care, change and change. The practice of transferring patients between nurses during shift changes was an important process in the practice of clinical care. It allows nurses to share necessary patient information, ensure continuity of care and promote patient safety. Most transfers are outside the patient's room without being involved or involved. The National Joint Patient Safety Targets for the Joint Commission included the requirement to encourage patients to actively participate in their care and to implement a standardized transfer communication process in the event of a change in caregiver. Developing a standardized process for transferring nurses to bedside nurses is one way to meet these two patient safety standards. Patients who have had bedside surgery have reported feeling safer. They also understand that they know their care plans and will be introduced to the future nurse {Marashi, 2024 #30}. Patients who are actively involved in transferring nurses to nurses are more likely to contribute to their care plans. It was found that patients often did not actively participate in handover sessions. In most cases, patients simply provided information when asked by nurses, and the use of medical jargon further confused them, limiting their involvement. Some patients also reported feeling too tired to engage. However, participation increased when patients were explicitly encouraged to ask questions and share comments during bedside handovers, highlighting the importance of clear communication and patient invitation in promoting engagement. In the past, nurses were reluctant to set up beds at the bedside, believing that it would take a lot of time. However, the implementation of bedside handovers resulted in a reduction of 100 hours of overtime within the first two pay periods. The handover process took only 2 to 5 minutes per patient. By conducting handovers at the bedside, nurses were able to better visualize all their patients, allowing them to prioritize tasks more effectively and manage their shift work more efficiently (Pinto, F., et al. (2025). This study also found that caregivers were increasingly satisfied with responsibility, interpersonal relationships and information. An unexpected result was increased physician satisfaction as caregivers were more willing to respond to questions shortly after shift changes. In summary, the benefits of bedside nursing are better communication between caregivers, increased accountability, and increased patient safety. There is also potential for reducing overtime. At the bedside, the infirmary can provide an opportunity to contribute to their care plans. All of these benefits increase the quality and safety at the bedside Kuhlmann, M., et al. (2025)

METHODOLOGY

The chapter provides an explanation of the research methodology in the study. It provides an overview of a sample study and sampling technique. This chapter the

study's settings, ethical considerations, eligibility requirements, data collection tools, data gathering and data analysis process.

Sample Size

The sample size was (90) nurses was selected from population by using sample size calculator Rao soft.
The margin of error 5%.
The confidential level 95%.
The total population 117.
The sample size 90.

Validity and Reliability

Validated questionnaire (Toll NHIQ= Nursing Handover Improvement Questionnaire) was adopted, the permission was obtained and show strong internal consistency (Cronbach's alpha=0.76).

Sampling Technique: Purposive Technique Applied

Study Area

This research was done in Liaquat university Hospital Hyderabad In Hyderabad has one Tertiary care hospital which have different department also different surgical wards and provide good health sciences for this town population as well as other district of Sindh.

Study Design

This descriptive Cross-sectional study was done to assess nursing handovers.

Study Population

This study includes all nurses worked in Surgical wards Liaquat university hospital Hyderabad.

Duration of Study

Study was carried from February 10, 2025 to June 10, 2025.

Eligibility Criteria

Inclusion Criteria

- Registered nurses working in surgical wards at LUMHS Hyderabad.
- Nurses involved in shift-to-shift patient handovers.
- Willing to participate and provide informed consent.

Exclusion Criteria

- Nurses from non-surgical departments.
- Nurses who refuse to participate in the study.

Data Collection Tool

The data was collected by closed ended questionnaire, designed by researcher based on reviewing of literature, it consists of four section the first section contain questions designed to collected demographic data, the second section question designed to collected knowledge of nurses regarding the Current Handover Practices and third section question designed collect knowledge about Handover Quality and Challenges, and four section designed to collect knowledge regarding Suggestions for Improvement.

Ethical Consideration

Research study is conducted with certain rules and regulations of ethics. Violation of ethical code is highly discouraged. During the study, ethical issues may develop to carry on social research. Therefore, all necessary efforts will be utilized that must ensure right to privacy and security of participants. Objectives of study would be made explicit and clear to the participant by explaining them the purpose of this research. Simply all ethical codes will be observed as the prerequisite in research studies.

1. Permission to conduct study was taken from the Director of Nursing and Medical Superintendent of Liaquat University of Medical and Health Sciences (LUMHS), Jamshoro.
2. Informed written consent was taken from the students after explaining about study.
3. Surety guidance was provided and assured that research process will not affect the participants.
4. Record was used for research purpose only and confidentiality of all information was maintained hence all questionnaires were kept in safe custody, names were not mentioned.

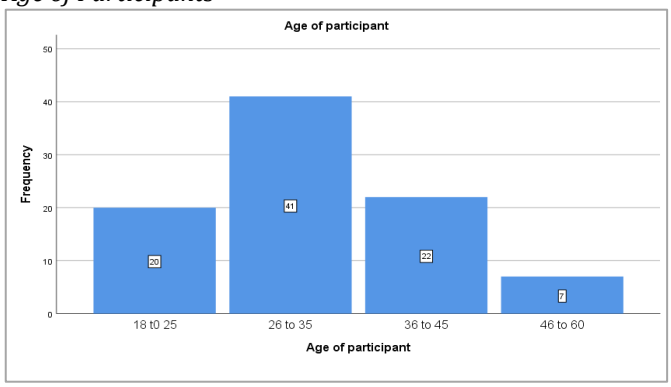
Data Analysis

The observed data was analyzed in SPSS 23 version to find the results. After entering the data, the next step was data analysis. In this step, only descriptive analysis was done and those tests were interpreted in order to extract the required information. This step was done with the guidance of preceptor. Data was analyze using Statistical Package for Social Sciences version 23.0 for windows. The frequency and percentage of all variables.

RESULTS

Figure 1

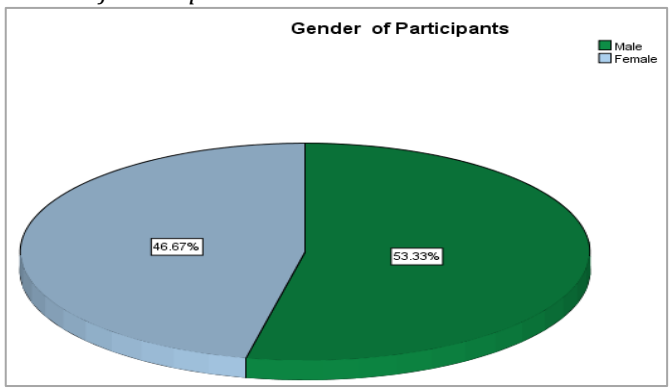
Age of Participants



In my study total 90 respondents were participated out of them 21 (20%) were between the age 18 to 25 years, 43 (41%) were between 26 to 35 years old, 22 (22%) were between 36 to 45 years old and remaining 8 (7%) were between the age of 46 to 60 years old which are shown in above chart.

Figure 2

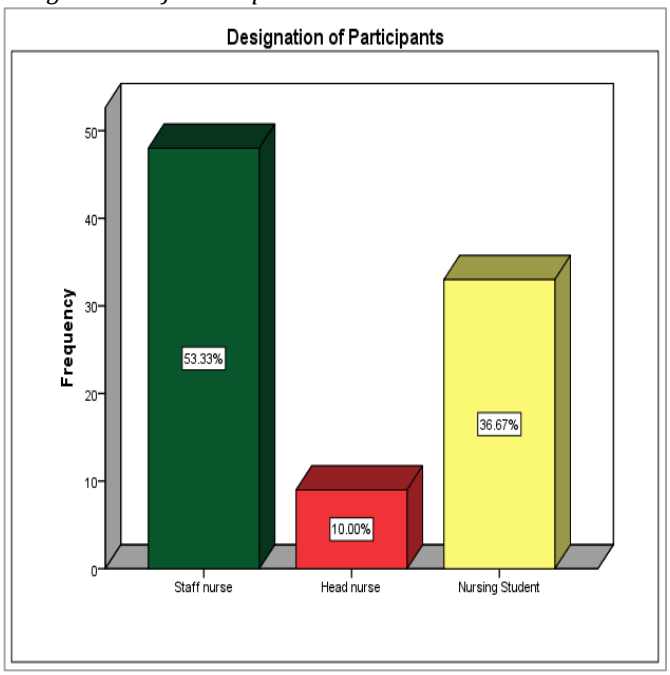
Gender of Participats



Total of 90 Respondents participated in my study, 46.65% of them were female and 53.33% were male as shown in table.

Figure 3

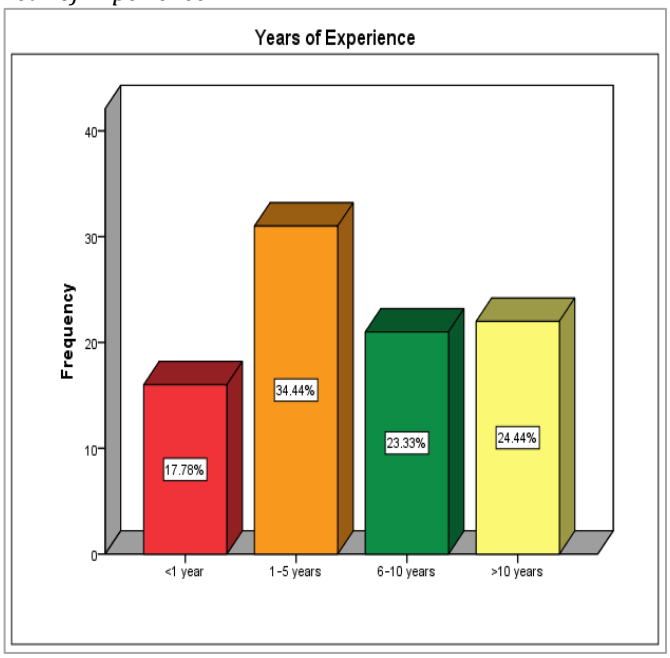
Designations of Participants.



There were 90 nurses participated in my study which of them were 48(53.33%) staff nurse, 9 (10%) were head nurse and 33(36.67%) were nursing students.

Figure 4

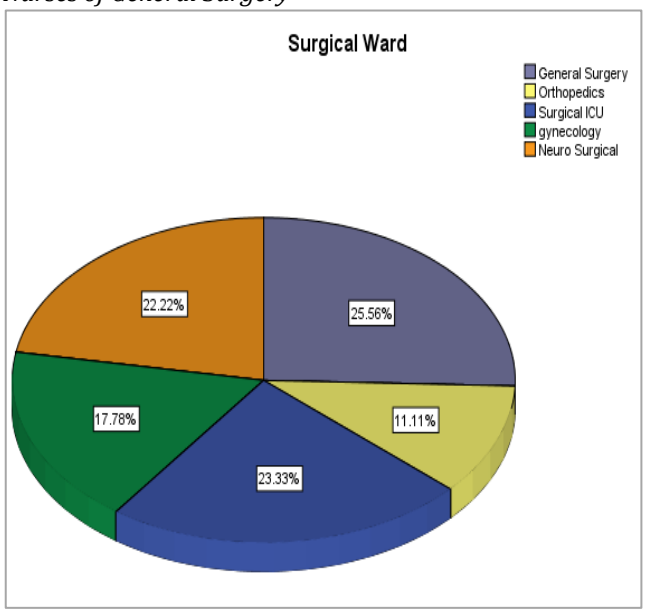
Year of Experience



These participants were categorized based on their years of experience. The most of them proportion (34.44%) had 1–5 years of experience. This was followed by 24.44% who had more than 10 years of experience, and 23.33% with 6–10 years of experience. The smallest group (17.78%) had less than 1 year of experience. This distribution shown in above figure that the majority of respondents had more experience 1-5 year in their field.

Figure 5

Nurses of General Surgery



There were 25.56% participate nurses General Surgery, 11.11% participate nurses Orthopedics ,23.33% participate nurses Surgical ICU, 17.78% participate nurses Gynecology and 22.22% participate nurses Neuro Surgical.

Table 1

How handover is usually conducted in your ward?

	Verbal Only	Written Only	Verbal +Written	Bedside Handover	Total
Frequency	23	12	40	15	90
Percentage	25.6	13.3	44.4	16.7	100

Interpretation

Above table shows how handovers are usually conducted in the ward based on responses from 90 participants. The most common method was a combination of 40 Participants verbal and written handover follow by 40 participants (44.4%), followed by 23 Participants verbal only (25.6%). 15 Participants Bedside handovers accounted for 16.7%, while 12 written-only handover was the least used method at 13.3%. This indicates a preference for using both verbal and written formats to ensure effective communication during handovers.

Table 2

Is there a standard format used during handover (e.g., SBAR)?

	Yes	No	Not Sure	Total
Frequency	36	44	10	90
Percentage	40	48.9	11.1	100

In this present study, a total of 90 respondents participated. Among them, 36 (40%) reported that a standard format (e.g., SBAR) is used during handover. However, 44 (48.9%) participants stated that no standard format is followed during the handover process. The remaining 10 (11.1%) respondents were not sure about the use of any standard format. This suggests that while some wards maintain structured communication, a significant portion still lacks standardized handover practices.

Table 3

On average, how much time is allocated for handover?

	<5 minutes	5–10 minutes	11–15 minutes	>15 minutes	Total
Frequency	13	28	24	25	90
Percentage	14.4	31.1	26.7	27.8	100

According to above data interpretation, Total 90 respondents, 28 (31.1%) reported that the average time allocated for handover is 5–10 minutes, while 24 (26.7%) stated it takes 11–15 minutes. Additionally, 25 (27.8%) participants indicated that handover takes more than 15 minutes, and only 13 (14.4%) said it takes less than 5 minutes. This indicates that the majority of handovers last between 5 to 15 minutes, with a notable portion exceeding 15 minutes, reflecting variability in time allocation across wards.

Table 4

Is the handover done in a quiet and disturbance-free area?

	Yes	No	Total
Frequency	62	28	90
Percentage	68.9	31,1	100

The above data shows that out of 90 participants, 62 (68.9%) reported that the nursing handover was conducted in a quiet and disturbance-free area, while 28 (31.1%) indicated it was not. This suggests that a majority of handovers occurred in an environment conducive to effective communication.

Table 5

How often are important details missed during handover?

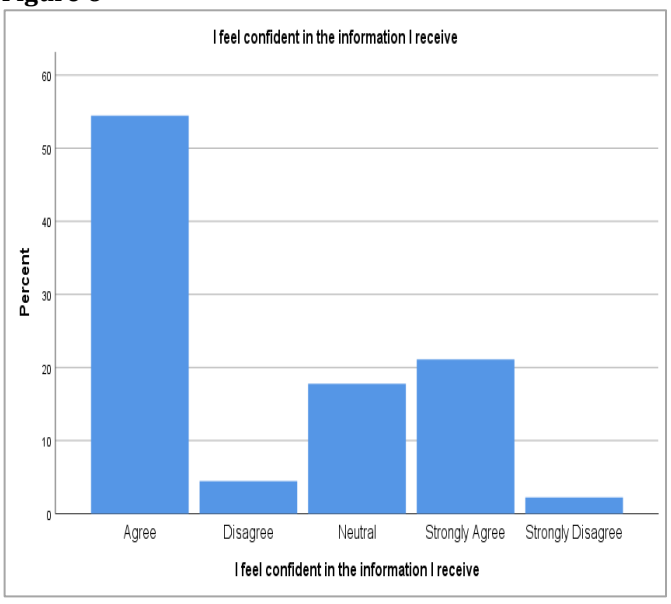
	Never	Rarely	Sometimes	Often	Always	Total
Frequency	32	25	28	5	0	90
Percentage	35.6	27.8	31.1	5.6	0	100

The data reveals that 32 (35.6%) of participants reported that important details are never missed during handover, while 25 (27.8%) said such instances occur rarely. About 28(31.1%) acknowledged that information is sometimes missed, and 5(5.6%) noted it happens often. No any respondents selected "always." This indicates that although handovers are generally reliable, occasional lapses in detail-sharing do occur.

Table 6

Nursing Handover Improvement Items	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree	
	Frequency	%	frequency	%	Frequency	%	Frequency	%	frequency	%
I feel confident in the information I receive	2	2.2	19	21.1	16	17.8	4	4.4	49	54.4
I have enough time to give/take handover effectively.	2	2.2	26	28.9	10	11.1	6	6.7	46	51.1
I experience frequent interruptions during handover.	37	41.1	11	12.2	22	24.4	18	20.0	2	2.2
The current handover method ensures patient safety	1	1.1	36	40.0	13	14.4	6	6.7	34	37.8
I have received formal training on effective handover practices	2	2.2	29	32.2	16	17.8	12	13.3	31	34.4

Figure 6

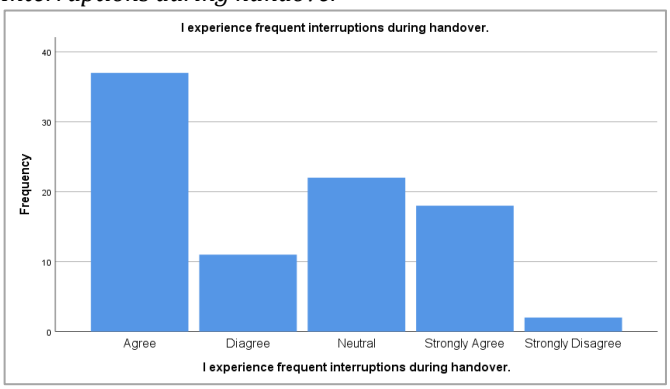


1. Above table significant portion of that they feel confident in the information they receive, while only respondents A small portion Strongly Agree 2(2.2%), Agree 19(21.1%), 16(17.5%) Remained Neutral, disagree 4 (4.4%) and majority of participants49 (54.4%) strongly disagreed, indicating a lack of confidence in the handover information. These findings suggest that a significant proportion of nurses are not confident in the accuracy or completeness of information shared during handovers, highlighting the need for structured and clear communication strategies to improve handover practices the current handover method ensures patient safety.

2. In above table shows nurses have enough time to give/take handover effectively Totally 90 respondents participated the results indicate that a large proportion of respondents 46 (51.1%) strongly disagreed with having enough time for effective handover, while 6(6.7%) disagreed, showing that nearly 58% feel time is insufficient. Meanwhile,26 (28.9%) of participants agreed, and only 2(2.2%) strongly agreed, suggesting that a smaller group feels time is adequate. About 10 (11.1%) remained neutral. This data reflects a significant concern regarding time constraints during nursing handovers, emphasizing the need to allocate sufficient and structured time to ensure safe and complete transfer of patient information, showing time constraints as a major concern.

Figure 7

Interruptions during handover



I experienced frequent interruptions during handover. The data reveals that interruptions during handover are a significant issue. A large portion of respondents Strongly Agree 37(41.1%), and 21(12.2%) agreed that they frequently experience interruptions, 22(24.4%) remained neutral, while 18 (20%) disagreed, and only2 (2.2%) strongly disagreed. This shows that more than half (over 53%) of the participants acknowledge frequent disruptions, which can negatively affect the quality and accuracy of information exchange during handovers. These findings highlight the need to implement strategies to reduce interruptions and ensure a more focused and effective communication process among nursing staff. Frequent interruptions during handover, indicates that interruptions are a common issue, affecting handover quality.

The current handover method ensures patient safety?

In response to this nursing handover method, the current handover method ensures patient safety, the data reveals a mixed perception among participants. Out of 90 respondents, only 1 (1.1%) strongly agreed, while 36 (40.0%) agreed that the current handover process contributes to patient safety. 13 respondents (14.4%) remained neutral, indicating uncertainty or mixed feelings. However, 6 participants (6.7%) disagreed, and a significant portion—34 respondents (37.8%)—strongly disagreed with this handover method. These findings suggest that while a notable number believe the current method has some effectiveness, a large group lacks confidence in its ability to ensure patient safety. This highlights the need for improvements in the handover process, particularly through structured communication tools and standardized protocols, aligning with the study's aim of improving nursing handovers. Responses are mixed, suggesting uncertainty or lack of trust in the current method. Patient Safety Ensured by Current Handover Method.

I have received formal training on handover practices

According to this questioner nurses have received formal training on effective handover practices received varied responses reflecting a gap in training among participants. Out of 90 respondents only 2 (2.2%) strongly agreed, and 29 (32.2%) agreed that they had received formal training. However, 16 respondents (17.8%) were neutral, indicating uncertainty. Notably, 12 participants (13.3%) disagreed, and a significant 31 (34.4%) strongly disagreed. This suggests that the majority of participants either have not received or are not confident in the formal training they've had on handover practices. The data highlights the need to implement structured and consistent training programs to improve the quality and safety of nursing handovers, which aligns with the overall aim of enhancing handover effectiveness in clinical settings. Indicating a clear gap in training and capacity-building efforts.

Table 7

In your opinion, what are the main barriers to effective handover?

	Frequency	Percentage
Time Management issue	31	34.4
No standard Format	10	11.1
Communication issues	9	10.0
No Proper discipline	14	15.6
Staff Shortage/Overburdened Patient	14	15.6
Other	3	3.3
No	9	10.0
Total	90	100

The data collected on perceived barriers to effective nursing handover highlights several critical issues. The most frequently cited barrier was time management reported by 31 participants (34.4%). This suggests that nurses often struggle to allocate sufficient time for proper handovers, potentially due to workload or shift patterns. Lack of proper discipline and staff shortage/overburdened patients were each identified by 14 participants (15.6%), indicating that inadequate staffing levels and lack of structured behavior during handover also hinder effectiveness. Additionally, no standard format was reported by 10 respondents (11.1%), and communication issues by 9 (10.0%), pointing to the absence of uniform protocols and communication clarity. A small number (3.3%) mentioned other reasons, while 10% selected "No", possibly indicating no major barriers perceived. These findings emphasize the urgent need for structured protocols, proper time allocation, discipline, and staffing improvements as part of strategies to enhance the quality and safety of nursing handovers.

Table 8

What methods or tools would you suggest to improve handovers in surgical wards?

	Frequency	Percentage
Implement SABR	10	11.1
Workshop	15	16.7
Checklist	26	28.9
Computer Based	9	10.0
Verbal/written/bed to bed	30	33.3
Total	90	100

The data collected regarding suggested methods to improve handovers in surgical wards shows that the majority of respondents (33.3%) preferred verbal/written/bed-to-bed handover, with 30 participants supporting this method. This reflects the perceived value of direct and personal communication in ensuring continuity of care. A significant portion (28.9%) recommended the use of a checklist (26 participants), indicating the importance of structured documentation to avoid omissions. Workshops were suggested by 15 respondents (16.7%), highlighting a need for practical, skill-based learning opportunities. Only 10 participants (11.1%) recommended implementing the SBAR (Situation,

Background, Assessment, Recommendation) format, while 9 (10%) supported computer-based handover tools, which may point to either unfamiliarity or limited access to digital systems. Overall, the responses emphasize the need for a combination of structured formats, personal interaction, and continuous training to enhance the quality and safety of nursing handovers in surgical settings. verbal/written and bedside handovers, along with structured tools like checklists and workshops, are considered the most effective strategies for enhancing handover practices in surgical wards.

Table 9

Would you support the implementation of a standard tool like SBAR for handovers?

	Frequency	Percentage
Yes	73	81.1
No	11	12.2
Maybe	6	6.7
Total	90	100

The question aimed to assess participants' support for implementing a standard communication tool like SBAR (Situation, Background, Assessment, Recommendation) in nursing handovers. Out of 90 total respondents 73 participants (81.1%) responded "Yes", showing strong support for adopting SBAR as a standardized tool to improve the structure, clarity, and safety of handovers.11 respondents (12.2%) answered "No "indicating a small proportion who are either not familiar with SBAR or prefer current handover practices.6 participants (6.7%) chose "Maybe", reflecting hesitation or a need for more information/training before deciding. These results clearly indicate that the majority of nurses recognize the importance of standardizing handover communication using a tool like SBAR. This aligns with the broader goal of enhancing nursing handover processes through structure, consistency, and improved patient safety. These findings suggest that most healthcare professionals surveyed recognize the potential value of standardized handover tools like SBAR in enhancing communication and patient safety in clinical settings.

Table 10

What are suggestions and recommendation to improve nursing handover?

Valid	Frequency	Percent
Implement Standard format (SBAR).	29	32.2
Provide Training, education about handover and documentation	15	16.7
Time management and Proper communication	6	6.7
Other	9	10.0
No	31	34.4
Total	90	100.0

The most commonly suggested solution was to implement a standard format such as SBAR, supported by 29 respondents (32.2%). This indicates a strong preference for structured communication during handovers. 15 respondents (16.7%) recommended providing training and education related to handover practices and documentation, emphasizing the need for better knowledge and skills among staff. 6 respondents (6.7%) highlighted time management and proper communication as key areas for improvement, reflecting the importance of workflow efficiency and clarity in exchanges.9respondents (10.0%) selected "others", suggesting alternative or unspecified methods to enhance handovers. Notably, 31 respondents (34.4%) marked "No", indicating they had no suggestions or perhaps felt no improvements were needed.

DISCUSSION

Efficient nursing handovers are crucial for maintaining patient safety and ensuring continuity of care, particularly in surgical wards where clinical complexity and risks are higher. This study, conducted at Liaquat University Hospital Hyderabad with the participation of 90 nurses, assessed existing handover practices, identified barriers, and explored potential strategies for improvement. The demographic profile of respondents showed that the majority were aged 26–35 years (41.1%), with 53.3% being staff nurses and 36.7% nursing students. Most participants had 1–5 years of professional experience (34.4%), indicating a relatively early-career workforce. This lack of extensive experience may influence handover efficiency, as newer nurses might not yet fully grasp or apply structured formats like SBAR {AlAmrani, 2022 #31}. Regarding current handover practices, 44.4% of nurses reported using both verbal and written methods, while only 40% utilized standardized formats such as SBAR. This lack of formalization is consistent with findings from Nigerian and Ethiopian studies (2024–2025), which also documented inconsistent handover approaches and limited use of mnemonic tools like ISBAR/SBAR. Time allocation for handover varied, with most handovers occurring within 5–15 minutes, while 27.8% extended beyond 15 minutes, highlighting variability and a lack of time standardization. Although 68.9% of handovers took place in quiet environments, over 53% of participants reported frequent interruptions, aligning with global concerns about environmental distractions compromising communication quality during transitions (Seid, A., et al. (2025)) When evaluating the quality of handovers, more than half of respondents strongly disagreed that they felt confident in the accuracy of the information exchanged. Similarly, 58% agreed that time constraints hindered effective handovers. Only 41.1% of respondents believed that current handover practices ensured patient safety, while 37.8% strongly disagreed. These findings reflect concerns noted in a 2021 experimental study where the implementation of SBAR protocols led to increased nurse confidence and higher patient satisfaction. Additionally, systematic reviews have linked structured handovers with a reduction in falls, pressure injuries, and medication errors by rates ranging from 11% to 80%. A significant gap in formal training was evident, with 34.4% of nurses strongly disagreeing that they had received any handover-specific training. This reinforces evidence from a 2025 cluster-randomized trial in Nigeria, which demonstrated that educational interventions significantly improved nurses' perceptions of handover quality (Martínez-Fernández, M. C., et al. (2022)). Key barriers identified in this study included time constraints (34.4%), poor discipline or staffing (15.6%), lack of handover protocols (11.1%), and general communication issues (10%). These obstacles are echoed in studies from South Wollo, Ethiopia,

and Nigeria (2022–2025) (Hada, A. and F. Coyer (2021)). Participants proposed various solutions to improve handover quality. A total of 11.1% recommended SBAR implementation, 28.9% suggested the use of checklists, and 33.3% advocated for bedside handovers. Additionally, 16.7% favored organizing regular workshops, while 10% endorsed the integration of digital handover tools. These suggestions align with international evidence; for example, a 2022 Turkish study demonstrated that SBAR significantly reduced communication errors, and a 2021 integrative review supported the positive impact of bedside handover protocols on interdisciplinary communication and patient outcomes. The digital shift was also reflected in a 2025 UK experience where electronic SBAR tools enhanced workflow efficiency. Notably, 81.1% of respondents supported SBAR as a preferred handover method Tomás, M. A., et al. (2025). this study emphasizes the need for immediate action to address deficiencies in nursing handover practices at Liaquat University Hospital Hyderabad. Standardized tools such as SBAR, targeted training programs, environmental improvements, and supportive policies are essential to enhancing communication quality, improving patient safety, and ensuring continuity of care in surgical wards.

CONCLUSION

This study, conducted to assess approaches for improving nursing handover in the surgical wards of Liaquat University Hospital Hyderabad, offered important insights into existing practices, challenges, and areas for improvement. A considerable number of nurses reported dissatisfaction and a lack of confidence in the information shared during handovers, highlighting the urgent need to enhance the accuracy, clarity, and completeness of communication. The investigation also revealed inconsistencies in handover practices across shifts and wards, with many nurses not fully adhering to standardized procedures. These inconsistencies often resulted in missing or unclear information, potentially compromising patient safety. The study further identified a positive link between staff experience and the perceived quality of handovers. Senior nurses were more likely to report effective and higher-quality communication, suggesting that experience significantly contributes to better handover practices. However, this finding also emphasizes the importance of structured training and mentorship for newer staff members. One of the most notable outcomes of the research was the recognized benefit of using structured handover tools, particularly the SBAR (Situation, Background, Assessment, Recommendation) format. Nurses who employed SBAR reported greater confidence and clearer communication, leading to more consistent and safer patient care. Additionally, the time allotted for handovers was widely seen as insufficient, often resulting in hurried or incomplete exchanges. Ensuring that adequate time is set aside for both giving and receiving handovers is crucial for thorough and effective information transfer.

Limitations

The quantitative nature of this study limits the generalizability of the findings to other settings. Furthermore, the findings, created from a single institutional study with a purposive sample at a single point in time, restrict generalization to a broader population of healthcare professionals in other healthcare settings. First, the data collectors were not directly involved in patient care, which limited their ability to assess the accuracy or clinical relevance of the handover content. Second, the presence of observers during data collection may have influenced the behavior of nursing staff, potentially leading to performance bias (Hawthorne effect). Lastly, since the study was conducted only in the surgical wards of LUMHS, the findings may not be fully generalizable to other departments or institutions with different protocols or work environments. One limitation of this study was the relatively small sample size. A larger sample could lead to stronger conclusions and a more precise p-value related to handover quality. Hence, future research is encouraged to include a greater number of participants to better assess the effectiveness of using a checklist during shift handovers. Another limitation involved observing shift-change handovers during surgery while the researcher was present in the operating room, which may have introduced the Hawthorne effect, potentially influencing behavior. However, this impact was minimized, as the observer did not interact with the surgical team and was consistently present during both pre- and post-intervention phases. Additionally, the researcher was not part of the surgical team and held no authority over them. Still, the observer's presence was essential for accurate assessment. In future studies, video recording could be used as an alternative to reduce observer bias while still capturing handover practices effectively.

Recommendations

Adopt a Standardized Handover Framework (e.g., SBAR)

SBAR (Situation, Background, Assessment, Recommendation), it is recommended that a standardized communication tool be implemented hospital-wide. SBAR enhances clarity, consistency, and completeness of information during handovers.

Conduct Regular Training and Workshops

Create uniform handover procedures and guidelines at the institutional and governmental levels to advance the likelihood of continuous application of best practices and participants emphasized the need for education, regular training sessions on effective handover communication, documentation, and the use of tools like SBAR should be organized. These sessions should be mandatory for new and existing staff.

Improve Time Management and Communication Strategies

pointed out workflow and communication issues, efforts should be made to streamline handover schedules, minimize interruptions, and create an environment that supports focused and efficient communication.

Encourage Staff Participation in Identifying Improvements

hospitals should foster open feedback mechanisms (e.g.,

suggestion boxes, focus groups) to collect innovative and department-specific ideas from nursing staff.

Address Staff Perception and Awareness

lack of awareness or perceived ownership in handover quality. Awareness campaigns and leadership engagement can help reinforce the importance of handover and motivate staff to contribute toward improvements.

Monitor and Evaluate Handover Practices

Implement regular audits and evaluations to ensure adherence to protocols and to assess the impact of any interventions. Feedback from these evaluations should be used to refine the handover process continuously.

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