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Clinical Practice Guideline End of Shift Handover Toolkit

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Executive Summary: Clinical Practice Guideline

End of Shift Handover Toolkit

by

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Abstract

The DNP project is a Clinical Practice Guideline (CPG) to guide nurses in performing end-of-shift reports at a Medical Center in the West Indies. The gap in practice identified is that nurses perform end-of-shift reporting without using a standardized document. This affects patient safety because the absence of a structured handover process disrupts the continuity of patient care and the transmission of vital patient data. The nurse administrator and general manager reported that many adverse events at the facility were related to miscommunication of information among nurses. The purpose of the project was to develop a CPG that nurses will use to communicate effectively during the end-of-shift handover of patient care. I developed the CPG using evidence-based information to guide the nurses in communicating effectively during the end-of-shift handover. Three experts reviewed the CPG using the Appraisal of Guidelines for Research and Evaluation (AGREE) II tool. They agreed that the CPG had content validity. The handover toolkit (See Appendix C) developed from the CPG was shortened by replacing some of the original items that required written comments with a check box as recommended by the experts. The CPG is an end-of-shift document that will guide nurses in communicating the vital details of the patient's handover so that the taking-over nurse will have all the vital data necessary for proper continuity of care. It can potentially enhance nurses' clinical reasoning, critical thinking skills, and culturally competent care. I recommend that the facility include the CPG in the orientation process for new nurses. The positive social implication of the CPG is that nurses will engage in an evidence-based handover process to improve patient safety and enhance the profession.

Background

At one of the Medical Center in the West Indies, there is no standardized document for registered nurses to use for the end-of-shift reporting. This affects patient safety because the absence of a structured handover process disrupts the continuity of patient care and the transmission of vital patient data. Without a standardized document for the handover process, the responsibility and accountability of the nurses are unclear, and near misses relating to medication errors, delays in diagnostic tests and reporting of results, and reporting of treatment plans are not up to date. The project question is as follows: Will developing a clinical practice guideline (CPG) related to purposeful rounding provide valid evidence-based information nurses can use to communicate essential data during end-of-shift reporting? The project aims to develop a Clinical Practice Guideline that will provide an evidence-based structure nurses can use to communicate essential data during end-of-shift reporting as determined by experts using the (AGREE II) guidelines. The CPG will provide nurses with essential information that must be communicated during end-of-shift handover to ensure the continuity of patient care and the transmission of vital patient data

I searched the literature in Walden Library using the following databases: EBSCO, Medline, Ovid, PubMed, PubMed Central, Google Scholar, ERIC, BioMed Central, Embase, and CINAHL. Data was acquired from the Cochrane Database of Systematic Reviews and the Nursing Council's Guidelines. I used the following keywords: end-of-shift reporting, structured patient handover, shift handover, registered nurses, SBAR toolkit, handover framework, handover document, handover toolkit, effective communication, and misunderstanding during handover. The evidence and

quality to support the CPG were rated using the Johns Hopkins Evidence-Based Practice model. Thirteen articles were retrieved that facilitated the development of the CPG. There were 9 Level I, 2 Level II, 14 Level III, 1 Level lV, and 8 Level V. The quality of the resources that were used to inform this CPG were all rated B.

The end-of-shift document facilitates vital information communication, enhances nurses' clinical reasoning and critical thinking skills, and improves patients' care (Kwame & Petrucka, 2019). Hada and Coyer (2021) systematically reviewed eight studies relating to handover documentation. They identified that using a structured handover document directly impacted decreasing fall rates, medication errors, and pressure injuries. The medical-surgical units in an Indonesian hospital adopted a structured handover document, which resulted in a 20% increase in documentation, a 17% increase in communication, and a 16% increase in communication (Lindayami & Yeti, 2021). A structured handover allows for effective prioritizing of patient care because the handover document guides the reporting process so that critical information is communicated and documented; this facilitates effective prioritizing of patient care (The Australian Commission on Safety and Quality in Health Care, 2024). The ability of nurses to communicate effectively during the end-of-shift handover of patient care is one of the defining characteristics of high-quality continuity of patient care. Ghosh and Ramamoorthy (2021) reported that a formal structured handover document increased patient satisfaction with the care they received compared to an informal handover process without using a handover document. In a study by Clark et al. (2020), a structured document for bedside handover among registered nurses increased patient satisfaction and decreased patient falls. Thaeter et al. (2018) reported that 80% of healthcare errors are related to ineffective communication

during patient handover. In addition, Pun et al. (2020) cautioned that maleficence and neglect in patient care may result if nurses fail to convey crucial components of patient care effectively and promptly. Nursing practice is organized and given structure through documentation. It allows for continuity of care, which benefits the nurse and the patient. This DNP project developed a CPG that will provide nurses with evidence-based information to facilitate quality patient-centered communication and continuity of care.

Clinical Practice Guideline Development

I developed the evidence-based CPG using information from the literature and collaborating with the project mentor. The elements of the SBAR tool include the fundamental items for end-of-shift reporting (See Appendix A). The Situation-Background-Assessment-Recommendation (SBAR) is a structured framework that directs intra- and inter-disciplinary communication, facilitating the exchange of vital information about patient care within the multidisciplinary and was developed by the Institute for Healthcare Improvement (IHI; 2023). The SBAR tool has been adopted to guide the development of the end-of-shift handover toolkit. The World Health Organization Cooperation Centre recommended using the SBAR toolkit, which helps determine patients' conditions, adverse events, and current medications (Beigmoradi et al., 2019). It is an evidence-based structured framework that provides essential guidelines for nurse communication when exchanging shifts to ensure that vital information regarding patient care is disseminated among the multidisciplinary team (IHI, 2023).

After obtaining the approval of my committee and Walden University Ethics Pledge approval, I presented the CPG to three expert reviewers. The experts reviewed the CPG using the Appraisal of Guidelines for Research and Evaluation (AGREE) II tool

(See Appendix B). The AGREE II tool is an instrument that was developed by the principal investigator, Dr. Melissa Brouwers, and consortium members to assess the quality of clinical practice guidelines for transparency, validity, and usability. The Agree II instrument contains 5 Domains (See Appendix B). Each expert reviewer has been in the nursing profession for over 25 years. One is a nurse manager; the other two are nurse supervisors in the intensive care unit. The project manager conducted two education sessions with the expert reviewers on using the Agree II instrument. The five domains of the Agree II instrument were discussed in the teaching session, and a comprehensive explanation of all 21 items in the questionnaire was provided (See Appendix B). Domain 6 was not included because there is no funding body for this project. The expert reviewers conducted several meetings to complete the evaluation of the CPG**.** All expert reviewers completed their scoring of the CPG on a handprinted document containing the items of the Agree II instrument.

Results

The scores from all three expert reviewers were determined using the AGREE II recommended formula (Brouwers et al., 2010). The results from the three expert reviewers were calculated by summing up all the scores from the individual items in a domain and by scaling the total as a percentage of the maximum possible score for that domain. The formula used the following: obtained score-minimum possible score/maximum possible score-minimum possible score * 100 (Brouwers et al., 2010). Maximum possible score = 7 (strongly agree) x 3 (items) x 3 (appraisers) = 63 Minimum possible score = 1 (strongly disagree) x 3 (items) x 3 (appraisers) = 9. Using the formula, the scores were as follows: Domain 1 scored 85%, Domain 2 scored 74%, Domain 3

scored 83%, Domain 4 scored 94%, and Domain 5 scored 57%. The quality score of the three experts for each of the domains was calculated (Appendix A). In addition, the total scores for all three experts were combined and converted to a percentage for each domain (see Table I).

Table 1

Expert Reviewers AGREE II Scores for Each Domain

Domain	Maximum Score	Minimum Score	Obtained Score	Quality Score
Domain 1	63	9	55	85%
Domain 2	63	9	49	74%
Domain 3	168	24	144	83%
Domain 4	63	9	40	57%
Domain 5	84	12	53	57%

The quality score for Domain 1 was 85%, indicating high quality for the three items under this domain. Using the Likert scale 1-7 (Strongly disagree to Strongly Agree), the expert reviewers had a total raw score of 16/21, 21/21, and 18/21, respectively (See Appendix B) for the three items under domain. Domain 2 had a quality score of 74%, which indicates a high-quality score for the three items under this domain. The expert reviewers had total raw scores of 15/21, 16/21, and 18/21, respectively, for the three items under domain 2. Domain 3 had a quality score of 83%, which indicates a high-quality score. Expert reviewers had a total raw core of 43/56, 53/56, and 48/56, respectively, for the eight items under domain 3. Domain 4 had a quality score of 57%. This domain refers to the clarity of the presentation. A score of 57% does not indicate that the recommendations were unclear. In this domain, item 16 was not included in the scoring because this CPG was not designed for any specific disease or health condition.

This would have affected the overall quality score using the agree II formula. Expert reviewers had a total raw core of 11/14, 12/14, and 12/14, respectively, for the two items under domain 4. Domain 5 also had a quality score of 57%. Expert reviewers had a total raw core of 22/28, 14/28, and 17/28, respectively, for the four items under domain 5. For item 20 under domain 5, expert reviewer 2 scored 1. This reviewer commented that there was very little discussion about the cost of implementing the project in the CPG.

The three expert reviewers recommended revising the end-of-shift reporting document so that the maximum time for end-of-shift reporting is not lengthy. The CPG remained the same so that nurses would be fully informed about all essential items that must be communicated during end-of-shift handover. However, the handover toolkit (See Appendix C), which was developed from the CPG was shortened by replacing some of the original items that required written comments with a check box. The expert reviewers agreed with the changes.

The CPG is designed to provide nurses with guidance on how to provide important patient information. According to Toumin et al. (2024), using a standardized document toolkit for end-of-shift reporting helps nurses overcome linguistic and cultural obstacles and ensures accurate reporting. The reviewers and the facility administrators also agreed that the handover document would strengthen nurse communication, encourage teamwork and continuity of care, and improve patient outcomes.

A limitation identified for the implementation of the CPG is that nurses will have a certain degree of resistance to use the CPG. This is because they are accustomed to an informal verbal handover that does not require a standardized document. Nurses might view this CPG as time-consuming because they must document all the essential data for

the end-of-shift reporting. To overcome this challenge, workshops and seminars will be conducted with the nurses to highlight the benefits of adopting the CPG.

This project is important beyond the local site because other healthcare institutions in the West Indies do not have a structured document for end-of-shift reporting. The stakeholders from these healthcare settings have expressed an interest in utilizing a CPG for the end-of-shift reporting.

Conclusions

Using the CPG will enable the on-coming nurse to be fully informed about the patient's condition and plan of care. The CPG will allow nurses to engage in comprehensive end-of-shift reporting, leading to quality patient care. The World Health Organization Cooperation Centre recommended using the SBAR toolkit, which helps determine patients' conditions, adverse events, and current medications (Beigmoradi et al., 2019). The use of a structured handover toolkit has the potential to improve nursing practice through an evidence-based guideline. With the use of the Agree II tool, three experts evaluated the CPG. All experts agreed that this tool should be implemented for end-of-shift reporting. The project mentor and the experts agreed that the CPG would remain the same, but checkboxes would replace items on the handover toolkit that require written comments. The recommendation is that CPG and the handover toolkit should be presented to all new nurses during orientation. The CPG guidelines have the potential for positive social change by improving nursing practice and patient outcomes. Nurses will be empowered with current evidence-based practice to more efficiently provide the on-coming nurses with information that has the potential to increase the continuity of care for their patients. In addition, improving interpersonal communication and the quality of

care nurses provide to their patients can potentially improve their job satisfaction. Communicating current information about the care needed for each patient can increase patient satisfaction with the care they receive. It can also improve care outcomes and optimize nursing care, which will positively impact social change. The CPG will be evaluated annually to ensure the evidence is current and meets best practice standards.

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Appendix A: Evidenced-Based Clinical Practice for End-of-Shift Handover Toolkit

Objective

The purpose of this Doctor of Nurse Practice (DNP) project is to develop an evidence-based clinical practice guideline for registered nurses for end-of-shift reporting to facilitate systematic and structured communication during the handover process.

Problem Statement

In the facility, nurses provide information during shift-to-shift reporting. However, the information provided does not entirely reflect the information the incoming nurse needs to fully understand the patient's care needs.

Target Population

The Clinical Practice Guideline (CPG) was created to serve as a guide for registered nurses in the medical, surgical, and intensive care units of a medical center located in the West Indies to use as an end-of-shift handover document to decrease the gaps in communicating pertinent patient data. Although the main users of the CPG will be registered nurses, there will be collaboration with the multidisciplinary team for comprehensive patient data.

Guideline Monitoring

For validity and reliability of evidence, the CPG will be updated every 5 years as recommended by the National Institute for Health and Care Excellence and the American College of Physicians (Cardwell et al., 2021). At the organization there will be an annual review of the CPG and it will be updated as new evidence emerges regarding the items on the clinical practice guideline. The updated guideline will then be presented to the expert reviewers.

Evidence Search

To inform the CPG on best practices for end-of-shift handover reporting an extensive literature search was conducted in several databases that included primary sources of literature related to current evidence-based practices. The database included CINAHL, Medline, and EBSCO. Other supportive scholarly databases include Ovid, PubMed, PubMed Central, Google Scholar, ERIC, BioMed Central, and Embase. In addition, information was obtained from the Cochrane Database of Systematic Reviews, and Guidelines from the Nursing Council. The literature from these databases included peer-reviewed journals, publications, and guidelines within the last five years. The search was conducted using the following keywords: effective communication, miscommunication during handover, registered nurses, SBAR toolkit, handover framework, handover document, handover toolkit, end of shift reporting, structured patient handover, shift handover, and handing over process. The CINAHL combined with Medline in EBSCO host included the option for Boolean phrases. In the three boxes, I expanded the search by including phrases such as structured handover AND patient safety, miscommunication during handover AND maleficence, SBAR toolkit OR handover toolkit AND improve nursing practice. 24 articles were retrieved that informed the content of the CPG. The evidence and quality to support the CPG were rated using the Johns Hopkins Evidence-Based Practice model. There were 9 Level I, 2 Level II, 14 Level III, 1 Level lV, and 8 Level IV. The quality of the resources that were used to inform this CPG were all rated B.

Evidence that Supports A Structured Document for End-of-Shift Reporting

Nursing practice is organized and given structure through documentation. It allows for continuity of care possible, which is advantageous to the nurse and the patient. Eighty % of healthcare errors are related to ineffective communication during patient handover (Thaeter et al. 2018). An end-of-shift handover document can be used to properly and promptly document both existing and anticipated issues. The Australian Commission on Safety and Quality in Health Care (2024) identified that a structured handover allows for effective prioritizing of patient care because the handover document guides the reporting process so that critical information is communicated and documented.

A systematic review was conducted on 8 studies relating to a handover document. It was found that using a structured handover document directly impacted decreasing fall rates, medication errors, and pressure injuries (Hada & Coyer, 2021). Similarly, Ghosh & Ramamoorthy (2021), reported that a formal structured handover document increased patient satisfaction with the care they received in comparison to an informal handover process without the use of a handover document.

Table A1

SBAR Tool: Situation

Action	Recommendation	Level of Evidence	Comments	Source of Evidence
Reason for Admission	Highly Recommended	I	The reason for admission and chief complaint is recognized as an important item in the SBAR tool to improve patient outcomes and satisfaction.	Ghosh, S., & Ramamoorthy, L. (2021).
Current Status		I	The safety of patient care is compromised if nurses are not fully knowledgeable about the patient's condition during end-of-shift handover. The patient's updated condition must be included in the handover.	Pun, J. (2021).
Severity of Problem	Highly Recommended	III	It is critical to determine the allocation of hospital resources and influence patient outcomes. When the severity of the illness (SOI) is communicated, the nurse can prioritize nursing interventions and understand the patient's manifestations.	Xiang, J., Durance, P.W., Griffes, L.C., Chen, Y., & Bakshi, R. R. (2022). ALHosni, F., Al Qadire, M., Omari, O.A., Al Raqaishi, H., & Khalaf, A. (2023).
Vital signs upon admission and current vital signs	Strongly Recommend	III, IV	Vital signs are key for detecting abnormalities and predicting complications. Vital signs are also used as a patient safety indicator. When nurses neglect to communicate the abnormal vital signs during handover, this can lead to deterioration in the patient's condition and adverse clinical events.	Cross, R., Considine, J., & Currey, J. (2019). Elliott, M. (2021).
Physical complaints	Highly Recommended	III	The patient's physical condition and subjective data are essential to identify the patient's specific problem and improve health outcomes. Reporting the patient's complaints allows nurses to better understand the condition of the patient and it is a pathway for the nurse to establish a therapeutic relationship with the patient.	Rikos, N., Linardakis, M., Merkouris, A., Rovithis, M., & Philalithis, A. (2019). Lydon, S. (2021).
Psychosocial Complaints	Highly Recommended	III	Understanding the holistic needs of the patient allows healthcare providers to tailor and prioritize care both for the short-term and long-term. Also, the communication of the patient's psychosocial needs and complaints during handover has proven to increase patient satisfaction and level of confidence in the care received.	Rikos, N., Linardakis, M., Merkouris, A., Rovithis, M., & Philalithis, A. (2019). Ingstad, K., Pedersen, M. K., Uhrenfeldt, L., & Pedersen, P. U. (2023).

(*table continued)*

Table A1 cont.

SBAR Tool: Situation

Action	Recommendation	Level of Evidence	Comments	Source of Evidence
Family Concerns	Highly Recommended	V, III	The understanding of family concerns can optimize patient care and allow for partnership between family members and healthcare providers. The consideration of family concerns among nurses has proven to increase the well-being of the family unit.	Prior, S. J., & Campbell, S. (2018). Shamali, M., Konradsen, H., Stas, L., & Østergaard, B. (2019).
Risk for fall	Strongly Recommend	III, V	Nurses must assess all patients with risk factors for falls such as age, weight, neurological status, range of movement, and catheter in situ, and transfer this information during the end of shift reporting. This will contribute to reducing fall rates. Ninety percent of patients' falls during hospitalization can be prevented by relaying preventative measures during the end-of-shift reporting. These measures will include implementing precautions such as putting signs for wet floors, instructing patients to use call bells, locking the wheels of beds, advising patients on the type of slippers to wear, and performing a fall risk assessment.	Montejano-Lozoya, R., Miguel-Montoya, I., Gea-Caballero, V., Mármol-López, M. I., Ruíz-Hontangas, A., & Ortí-Lucas, R. (2020). Dykes, P. & Hurley, A. (2021).
Risk for infection	Strongly Recommend	I	The SBAR toolkit for end-of-shift reporting captures vital patient data that nurses will be able to analyze to determine the patient's risk for infection.	Ji, Y., Han, S., & Wang, B. (2021).
Contagious Diseases	Strongly Recommend	I	The SBAR toolkit allows for a structured handover of information relating to infectious diseases. This will allow nurses to implement interventions and precautions to promptly reduce the risk of spread.	Ji, Y., Han, S., & Wang, B. (2021).

Table 2

SBAR Tool: Situation

Actions	Recommendations	Level of Evidence	Comments	Source of Evidence
Admitting Diagnosis	Highly Recommend	III, I	Clear communication of the patient's diagnosis during the handover process allows for proper referrals and reduces gaps in nursing interventions. In the SBAR toolkit for handover, the B which represents background allows the nurse to communicate detailed information about the patient's admitting diagnosis. This is integral for the assignment of appropriate nursing skill mix and planning of specific patient care.	Lazzari, C. (2024). Ji, Y., Han, S., & Wang, B. (2021).
Is this a readmission? If so, what is the reason?	Highly Recommend	III	It is important to inform the taking-over nurse if the patient was readmitted so that the discharge instructions can be enhanced so that the patient and caregivers understand the instructions	Wieczorek-Wójcik, B., Gaworska-Krzemińska, Owczarek, A., Wójcik, M., Orzechowska, M., & Kilańska, D. (2022).
Allergies	Highly Recommend	III	Reporting patient allergies is key to preventing patient injury and adverse clinical outcomes. Allergies reporting should include allergy to food, medications, contrast dye, and any other substance. This will allow nurses to impose safety measures to prevent complications, morbidity, and mortality resulting from allergic reactions.	Sanjuan-Quiles, Á., Hernández-Ramón, P., Juliá-Sanchis, R., García-Aracil, N., & Perpiñá-Galvañ, J. (2019). Phadke, N. A., Wickner, P., Wang, L., Zhou, L., Mort, E., Bates, D. W., Seguin, C., Fu, X., & Blumenthal, K. G. (2022).
Past Medical History	Highly Recommend	V	The patient's medical history directs the healthcare provider to identify etiologic factors of present and acute patient problems. This allows for specific and accurate treatment. Medical history also allows for faster diagnosing of diseases and prevents delayed treatment. There is also reduced medication errors relating to administering of drugs to which a patient has an allergy.	Nichol, J.R., Sundjaja, J.H., & Nelson G. (2023).
Past Surgical History	Highly Recommend	V	The surgical history provides information on all invasive procedures, patient sensitivity to anesthetic, and alterations in organ functions.	Nichol, J.R., Sundjaja, J.H., & Nelson G. (2023).

(*Table continues)*

Table A3

SBAR Tool: Situation

Actions	Recommendations	Level of Evidence	Comments	Source of Evidence
Special Needs	Highly Recommend	II, V	Nurses should clearly understand the needs and perceptions of the patient even if these needs were not detected during the initial assessment or through diagnostic tests. The handover of patients with learning, communication, and adaptive disabilities is critical to assigning the appropriate nurse to that patient and providing essential supportive care. Nursing care tailored to address the special needs of the patient contributes to improved patient satisfaction.	Ingstad, K., Pedersen, M. K., Uhrenfeldt, L., & Pedersen, P. U. (2023). Khanlou, N., Khan, A., Landy, C. K., Srivastava, R., McMillan, S., & Vazquez, L. M. (2023).
Diagnostic and Lab Results	Highly Recommend	III	The analysis and communication of diagnostic and laboratory results can prevent patients from sentinel events	de Fátima Lucena, A., do Carmo Rocha Laurent, M., Reich, R., Correa Pinto, L. R., Carniel, E. L., Scotti, L., & Hemesath, M. P. (2019).
Cultural beliefs and preferences	Highly Recommend	III	The patient's culture and spiritual beliefs allow the nurse to integrate this knowledge to enhance the quality of care and establish a therapeutic relationship with the patient. Specifically, the patient's values, preferences, and beliefs allow nurses to provide specific care and holistic care to meet the unique needs of each patient. This improves patient satisfaction.	Hirschey, R., Tan, K. R., Petermann, V. M., & Bryant, A. L. (2021). Ndumbe-Eyoh, S., Muzumdar, P., Betker, C., & Oickle, D. (2021).
Social Determinants of Health	Highly Recommend	III	End-of-shift reporting on social determinants of health such as the patient's living condition, level of education, access to healthcare, access to medications, transportation, and home environment is essential for planning nursing interventions to optimize the quality of care. Social determinants of health allows nurses to advocate for patients and collaborate with other healthcare providers to enhance overall health.	Hirschey, R., Tan, K. R., Petermann, V. M., & Bryant, A. L. (2021). Yelton, B., Rumthao, J. R., Sakhuja, M., Macauda, M. M., Donelle, L., Arent, M. A., Yang, X., Li, X., Noblet, S., & Friedman, D. B. (2023).

Table A4

SBAR Tool: Background

Actions	Recommendations	Level of Evidence	Comments	Source of Evidence
Medical Diagnosis	Highly Recommend	I	The medical diagnosis is useful for formulating the nursing care plan, prioritizing patient care, and assigning responsibilities to nursing staff	Ghosh, S., & Ramamoorthy, L. (2021).
Nursing Diagnosis	Strongly Recommended	III	A nursing diagnosis was used as a quality care indicator and an international taxonomy because of its efficacy in preventing sentinel events and enhancing patient safety	de Fátima Lucena, A., do Carmo Rocha Laurent, M., Reich, R., Correa Pinto, L. R., Carniel, E. L., Scotti, L., & Hemesath, M. P. (2019).
Invasive or implanted devices	Strongly Recommend	V	The end-of-shift reporting must include information on implanted devices so that nurses can appropriately assess the patient for risk of infection, bleeding, complications, and abnormalities in the device and educate the patient and family on precautions.	Demir Korkmaz, F., & Çeliktürk, N. (2020). Fowler L. H. (2019).
Medications	Highly Recommend	I, V, I	Medication errors such as duplications of medication, administration of discontinued medications, omission of medications, and adverse medication can be avoided by including medication reconciliation in the handover document. Sixty percent of medication errors are attributed to errors in communication and omission of data. The SBAR tool is effective in reducing medication errors relating to miscommunication The handover should include a list of present medications and past medications. This reduces the risk of injury to the patient.	Tacchini-Jacquier, N., Hertzog, H., Ambord, K., Urben, P., Turini, P., & Verloo, H. (2020). Ji, Y., Han, S., & Wang, B. (2021). Raeisi, A., Rarani, M. A., & Soltani, F. (2019).

Table A5

SBAR Tool: Recommendations

Action	Recommendation	Level of Evidence	Comments	Source of Evidence
Medical Interventions	Highly Recommend	I	Medical management and treatment of the patient must be communicated during the end-of-shift handover reporting. The SBAR toolkit prevents the omission and miscommunication of vital data regarding the care of the patient.	Ji, Y., Han, S., & Wang, B. (2021).
Nursing Interventions	Strongly Recommend	I	The integration of the SBAR tool with the handover of nursing interventions enhances nursing practice because the comprehensive patient data will allow for a greater understanding of the patient's condition.	Ji, Y., Han, S., & Wang, B. (2021).
Referrals	Highly Recommend	III	The SBAR handover toolkit allows for clear and cohesive communication among nurses during the handover and other members of the multidisciplinary team for referrals to the specialist. Proper coordination of referrals through structured handover allows for successful referrals.	Toumi, D., Dhouib, W., Zouari, I. et al. (2024). Seyed-Nezhad, M., Ahmadi, B., & Akbari-Sari, A. (2021).
Discharge plans	Highly Recommend	V	Discharge planning must be based on multidisciplinary collaboration. A clear understanding of the discharge plans augments quality of patient care at home, prevents readmission, and allows for the priority allocation of resources by family members.	Patel, P.R., & Bechmann, S. (2023).

Table A6

Results from the Agree II Instrument Using the Likert Scale and Scored by Three Experts

Agree 11 Questionnaire and Scores	Expert Reviewer 1	Expert Reviewer 2	Expert Reviewer 3	Quality Score
Domain 1 Scope and Practice	16 Comments: Clearly stated in the introduction There is a problem statement	21	18 Comments: All other health professionals should be in the referral box in the handover toolkit.	85%
Domain 2 Stakeholder Involvement	15	16	18 All other health professionals should be in the referral box in the handover toolkit	74%
Domain 3 Rigor of Development	43	53	48	73%
Domain 4 Clarity of Recommendation	16	12	12	94%
Domain 5 Applicability	22	14	17	57%
OVERALL GUIDELINE ASSESSMENT				
Rate the overall quality of this guideline	5	5	6	
I would recommend this guideline for use. Yes _____ Yes with modifications _____ No _____	Yes, with modifications The guideline can condensed to shorten the duration of shift end of reporting	Yes, with modifications The guideline can condensed to shorten the duration of shift end of reporting	Yes, with modifications The guideline can condensed to shorten the duration of shift end of reporting	

Appendix B: Questionnaire Instrument

Sasha Samaroo-Burgos

Clinical Practice Guideline

Expert Evaluation

Doctor of Nursing Practice: NURS 8702

Walden University

AGREE II Questionnaire Instrument

Thank you for agreeing to evaluate the extent to which the Clinical Practice Guideline will serve to guide end of shift reporting among registered nurses. Please evaluate the content validity and usability of the guideline by responding to the following statements. Rate the statements from 1-7 (1=strongly disagree, 7=strongly agree). There is a comment section available for each question if needed.

AGREE 11 RATING TOOL

1	2	3	4	5	6	7
Strongly Disagree						Strongly Agree

Score of 1 (Strongly Disagree)-A score of 1 should be given when there is no information that is relevant to the AGREE II item, if the concept is very poorly reported, or if the authors state explicitly that criteria were not met.

Score of 7 (Strongly Agree)-A score of 7 should be given if the quality of reporting is exceptional and where the full criteria and considerations articulated in the User's Manual have been met.

Scores between 2 and 6-A score between 2 and 6 is assigned when the reporting of the AGREE II item does not meet the full criteria or considerations. A score is assigned depending on the completeness and quality of reporting. Scores increase as more criteria are met and considerations addressed.

Domain 1 Scope and Purpose:

1. The overall objective(s) of the guideline is (are) specifically described. _____

   Comments:

2. The health question(s) covered by the guideline is (are) specifically described.

   _____

   Comments:

3. The population to whom the guideline is meant to apply is specifically described.

   _____

   Comments:

Domain 2 Stakeholder Involvement:

4. The guideline development group includes individuals from all relevant

   professional groups. _____

   Comments:

5. The views and preferences of the target population have been sought. _____

   Comments:

6. The target users of the guideline are clearly defined. _____

   Comments:

Domain 3 Rigor of Development:

7. Systematic methods were used to search for evidence. _____

   Comments:

8. The criteria for selecting the evidence are clearly described. _____

   Comments:

9. The strengths and limitations of the body of evidence are clearly described.

   _____

   Comments:

10. The methods for formulating the recommendations are clearly described.

    _____

    Comments:

11. The health benefits and risks have been considered in formulating the

    recommendations. _____

    Comments:

12. There is an explicit link between the recommendations and the supporting

    evidence. _____

    Comments:

13. The guideline has been externally reviewed by experts prior to its committee

    review. _____

    Comments:

14. A procedure for updating the guideline is provided. _____

Comments:

Domain 4 Clarity of Recommendation:

15. The recommendations are specific and unambiguous. _____

Comments:

16. The different options for management of the condition or health issue are clearly presented. _____

    Comments:

17. Key recommendations are easily identifiable. _____

    Comments:

Domain 5 Applicability:

18. The guideline describes facilitators and barriers to its application. _____

    Comments:

19. The guideline provides advice on how the recommendations can be put into practice. _____

    Comments:

20. The potential resource implications of applying the recommendations have been considered. _____

    Comments:_

21. The guideline presents monitoring criteria. _____

    Comments:

OVERALL GUIDELINE ASSESSMENT

1. Rate the overall quality of this guideline. _____

Comments:

2. I would recommend this guideline for use.

   Yes _____

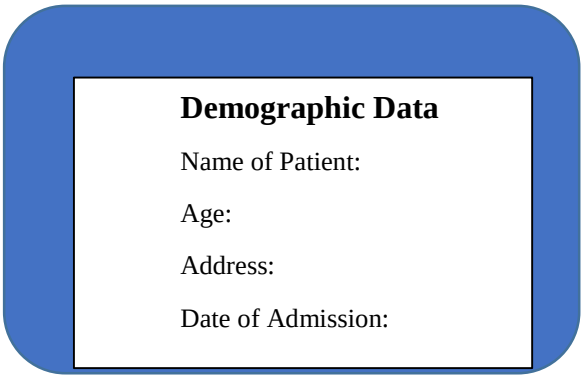
   Yes with modifications _____

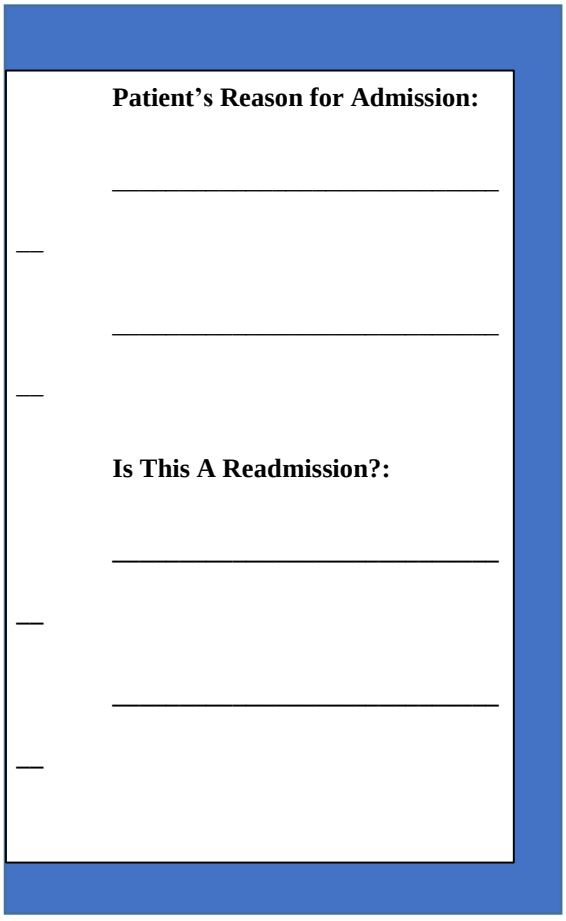
   No _____

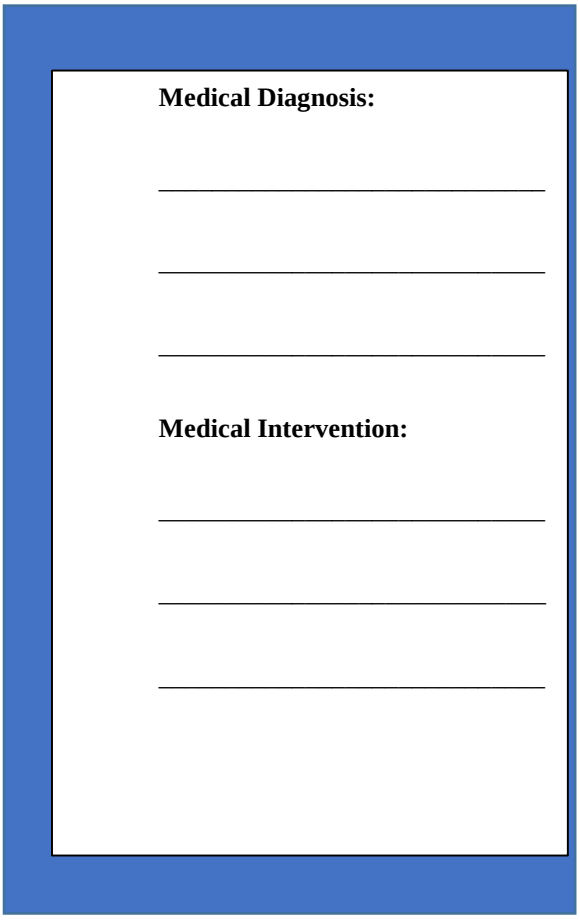
Reference

Brouwers, M. C., Kho, M. E., Browman, G. P., Burgers, J. S., Cluzeau, F., Feder, G., Fervers, B., Graham, I. D., Grimshaw, J. Hanna, S. Littlejohns, P., & Zitzelsberger, L. (2010). AGREE II: Advancing guideline development, reporting and evaluation in health care. *Canadian Medical Association Journal*, *182*(18), E839-E842.

Appendix C: Handover Toolkit







ALERT BOX

ALLERGIES:

DEFICITS:

SPECIAL NEEDS:

PRIORITY ORDERS:

Physical Complaints:

_____

_____

_____

Psychological Complaints:

_____

_____

_____

Nursing Diagnosis:

_____

_____

_____

Nursing Interventions:

_____

_____

_____

Diagnostic Results:

Pending Results:

Test Ordered for Today:

Psychosocial Assessment

Family Concerns:

_____

_____

Cultural Beliefs and Preferences

_____

_____

Social Determinants of Health

_____

_____

Dietary Needs

Hypertensive Diet: ☐

Diabetic Diet: ☐

Renal Diet: ☐

Vegetarian: ☐

Special Request:

_____

Identify Scars, Ulcers, Prosthetics or Invasive Devices