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Research Article

Nursing handover practices in the emergency department: A descriptive qualitative study

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ABSTRACT

Introduction: Nursing handover is a critical communication process for maintaining continuity of care and patient safety in emergency departments, where patient flow, clinical urgency, and workload may change rapidly. In high-volume situations, handover information may become incomplete, documentation may be rushed, and opportunities for family clarification may be limited. This study aimed to explore nursing handover practices in an emergency department, focusing on communication patterns, documentation, bedside validation, family involvement, and barriers during mass patient arrivals.

Method: A descriptive qualitative study was conducted at the Emergency Department of Buleleng Regional Hospital on April 5, 2026. Seventeen participants were selected using purposive sampling, consisting of one unit head, one deputy unit head, two team leaders, six nurses, and seven family members of patients. Data were collected through direct observation, semi-structured interviews, managerial discussion, and document review. The data were analyzed using descriptive thematic analysis.

Results: Five themes were identified: handover as a routine activity, inconsistent structured communication, selective bedside validation, limited family involvement, and suboptimal documentation during mass patient arrivals. Handover was routinely performed during shift changes, supported by verbal reports, medical records, handover logs, and report books. However, when patient volume increased, information transfer became shorter, bedside validation was not consistently conducted, family involvement remained limited, and documentation was sometimes incomplete.

Conclusions: Emergency nursing handover requires a more adaptive system that strengthens structured communication, concise documentation, selective bedside validation, proportional family involvement, and specific procedures for mass patient arrivals.

Keywords: *Diabetes Mellitus, Self-Management Education, Self-Empowerment*

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Background

The emergency department is a fast-paced, high-volume, and unpredictable setting because patients may arrive with varying degrees of urgency in quick succession [1]. In emergency care, patient safety depends not only on the speed of clinical interventions but also on the accuracy of communication among staff throughout the care process [2]. Delayed, incomplete, or inaccurate communication can disrupt the continuity of care, making effective communication a critical component of patient safety goals in hospitals [3].

Handover is the process of transferring information, responsibilities, and accountability for patient care from the nurse ending their shift to the nurse taking over [1]. Although it is performed routinely during shift changes, handover cannot be viewed as a mere administrative report because clinical decisions during the next shift heavily depend on the information received beforehand [1,4]. In the emergency department, this process becomes even more vulnerable because nurses must simultaneously cope with time pressure, environmental distractions, documentation burdens, and an increasing number of patients [5,6].

The use of structured communication such as situation, background, assessment, and recommendation can help nurses convey patient information in a more coherent, concise, and clinically action-oriented manner [7]. This approach has been reported to support patient safety, particularly in situations where clinical communication is at risk of being disrupted [7,8]. In addition to communication among nurses, the involvement of the patient's family is also important because family members often serve as a source of additional information, especially when patients are unable to fully explain their condition. However, family involvement in handoffs must be selective and take into account the patient's clinical condition, privacy, and emergency care priorities [9,10].

This situation is relevant to the services provided at the Emergency Department of Buleleng Regional General Hospital. Based on the unit's assessment data, the number of patient visits to the emergency department ranges from 30,000 to 50,000 per year, or approximately 2,000 to 2,500 patients per month. About 20% of these arrivals consist of mass influxes, in which 15 to 20 or more patients arrive almost simultaneously with varying disease characteristics and levels of severity. In such situations, handoffs risk being rushed, bedside validation is not always thorough, patient family involvement remains limited, and documentation is not always complete.

A number of studies have emphasized the importance of structured handoffs, bedside validation, situation-based communication, background information, assessment, and recommendations, as well as nursing supervision in ensuring patient safety [1,7,10,11]. However, studies describing nursing handover practices in the emergency departments of regional referral hospitals—particularly during periods of simultaneous increases in patient numbers—still need to be strengthened [5,6]. Given this gap, this study aims to explore nursing handover practices in emergency departments, focusing on communication patterns, documentation, patient verification, patient family involvement, and barriers during mass influxes. This article reports the findings of a descriptive qualitative study on nursing handover practices as a basis for strengthening clinical communication, continuity of care, and patient safety.

Method

Study design and setting

This study employed a qualitative method with a descriptive approach. This method was chosen because the study aims to provide an in-depth description of nurse handover practices in the Emergency Department, particularly regarding communication patterns, completeness of information, documentation, bedside validation, patient family involvement, and barriers that arise during simultaneous increases in patient numbers or mass visits [12]. The study was conducted at the Emergency Department of Buleleng Regional General Hospital on April 5, 2026

Participant and sampling

Participants were selected using purposive sampling based on their direct involvement in the handover process or their experience

accompanying patients during care in the Emergency Department [13]. There were 17 participants in total, consisting of 1 unit head, 1 deputy unit head, 2 team leaders, 6 practicing nurses, and 7 family members of patients. The inclusion criteria for nursing staff were being present during the handover process, being directly involved in patient care in the Emergency Department, and being willing to participate. Inclusion criteria for patients' families were accompanying the patient during care in the Emergency Department, being able to communicate effectively, not being in a state of severe distress, and being willing to provide information. Family members of patients facing critical emergencies, undergoing resuscitation, or in an emotional state that made participation impossible were excluded to ensure that the research process did not interfere with emergency care or compromise patient safety.

Data collection

Data were collected through direct observation, semi-structured interviews, discussions with ward management, and document review. Observations were conducted during the morning-to-afternoon shift handover at 2:00 p.m. Observations focused on the readiness of both shifts, reporting methods, the conveyance of patient information, the clarification process, bedside validation, patient family involvement, and handover documentation. Interviews were conducted after the handover process was completed to explore the experiences of the ward head, deputy ward head, team leader, and practicing nurses regarding the implementation of the handover and obstacles encountered during periods of high patient volume. Interviews with patients' families were aimed at understanding the extent to which families were aware of the nurse handover process, received explanations, were given the opportunity to ask questions, or were able to clarify information related to the patient's condition. The documents reviewed included medical records, handover logs, report books, handover standard operating procedures, and patient visit data from the Emergency Department.

Data analysis

The data were analyzed using descriptive thematic analysis. Data from observations, interviews, discussions, and document reviews were read repeatedly, reduced, coded, and then grouped into categories with similar meanings. These categories were then organized into main themes describing nursing handover practices in the Emergency Department, including handover preparation, handover implementation at the nurse station, structured communication, bedside validation, patient family involvement, handover documentation, and barriers during mass visits. The analysis was conducted in stages to ensure that the resulting themes reflected the field data and aligned with the research objectives **[14]**.

Trustworthiness

Data validity was ensured through source triangulation and methodological triangulation. Source triangulation was conducted by comparing information from the ward manager, deputy ward manager, team leader, nursing staff, patients' families, and ward records. Methodological triangulation was conducted by comparing the results of observations, semi-structured interviews, discussions, and document reviews. The analysis results were also discussed among the researchers to ensure consistency between the data, categories, themes, and interpretations developed [12].

Ethical considerations

The researcher explained the purpose, filling instructions, and assured data confidentiality, anonymity, and the right to refuse participation without consequence. Research ethics were applied by ensuring that all participants provided consent after a clear explanation (informed consent), and that all data collected were used solely for academic purposes. Ethical approval was granted by the Institutional Health Research Ethics Committee

Results and Discussion

Results

The results of this study describe nursing handover practices in the Emergency Department of Buleleng Regional General Hospital based on direct observation, semi-structured interviews, discussions with department management, and document review. The findings are organized into five

main themes corresponding to the study's objectives: routine handover procedures, structured communication patterns, bedside validation, patient family involvement, and documentation and challenges during periods of high patient volume. The presentation of results focuses on key findings without interpretation, while the interpretation of the results is presented in the Discussion section.

Based on Table 1, nurse handover practices at the Emergency Department of Buleleng Regional General Hospital have been carried out as a routine activity during shift changes. The main findings indicate that problems do not primarily arise during the preparation stage, but rather in the consistency of information sharing, validation, family involvement, and documentation when patient numbers increase simultaneously. During periods of high patient volume, handover tends to be shorter, while the need for clinical information actually increases. These findings highlight the need for a handover system that is more concise, focused, and aligned with the dynamics of emergency department care.

Table 1. Themes of nursing handover practices

Theme	Key findings	Illustrative quote
Handover as a routine activity	The handover was conducted at the shift change, supported by medical records, the handover log, the report log, and verbal communication.	Preparations are usually completed before the handover begins, including medical records and report books. (Ward Manager)
Structured communication is not yet consistent	Patient information is conveyed verbally and has followed the Situation, Background, Assessment, and Recommendation format, but has become more concise as the number of patients has increased.	We already use SBAR, but when there are a lot of patients, the briefing sometimes has to be done more quickly. (Nurse)
Bedside validation is still selective	Bedside validation is performed primarily on patients who are in critical condition or require immediate attention. Stable patients are not always validated directly.	Critically ill patients are usually assessed right away, but there isn't always time for stable patients. (Team Leader)
Family involvement remains limited	Patients' families are generally aware of changes in nursing staff, but they are not always given the opportunity to ask questions or clarify information.	We know that nurses come and go, but they usually just watch and don't ask any questions. (Patient's family)
Documentation and handover procedures during mass visits are not yet optimal	Documentation is carried out through medical records, handover logs, and report logs. When patients arrive at the same time, there is a risk that some information may not be fully recorded, and there are currently no specific procedures in place for handover during mass visits.	When there are a lot of patients, there isn't enough time to explain everything to each patient in detail. (Deputy Head of the Ward)

Discussion

The findings of this study indicate that handover procedures at the Emergency Department of Buleleng Regional General Hospital have become part of nurses' daily routines, but have not yet fully adapted to the demands of a high-volume care environment. The preparation of documentation, verbal reports, and nurses' presence during shift changes are initial strengths. However, these routines do not always guarantee the completeness of information when the workload increases. In the context of patient safety, transition points such as handoffs remain a high-risk area because incomplete information can influence clinical decisions during the next shift [1,2].

The use of structured communication following the Situation, Background, Assessment, and Recommendation framework emerged as a key finding. This framework helps nurses convey information in a more coherent manner, especially when reporting time is limited. However, the study results indicate that the application of this framework has not been consistent during mass visit situations. This reinforces the view that structured communication should not be understood merely as an individual skill but must be supported by concise formats, prioritized information flow, and ongoing supervision [7,11].

Bedside validation and the involvement of the patient's family remain areas that have not yet been optimized. In the emergency room, this situation is understandable because not all patients are stable, conscious, or able to be directly involved. However, the patient's family can still be an important source of information, particularly regarding medical history, allergies, changes in the patient's condition prior to admission, or the patient's response to specific symptoms. Therefore, family involvement should be conducted selectively, briefly, and with due regard for privacy and the priorities of emergency care [9,10].

The lack of consistency in handover documentation highlights the need for a more practical recording method. In the fast-paced and hectic environment of the emergency department, lengthy documentation can be burdensome for nurses, but documentation that is too brief risks omitting important information. A handover summary or checklist format based on Situation, Background, Assessment, and Recommendation may be a more realistic option because it helps nurses record priority information without slowing down patient care. Support from the unit head or team leader is also necessary to ensure that important information, unfinished tasks, and follow-up plans are consistently documented [1,2].

The main contribution of this study lies in the finding that handoffs in emergency departments require a more adaptive system during mass influxes. Routine handoff procedures are insufficient to address situations where patients arrive simultaneously, workloads increase, and reporting time is limited. Special procedures should include prioritizing information based on severity, using concise communication formats, establishing clarification mechanisms, minimizing documentation, and defining the role of the shift coordinator in ensuring a smooth handover. This study was limited to a single emergency department, and data collection was conducted over a short period; therefore, future research could evaluate the effectiveness of checklists or mass-arrival handover procedures on the quality of communication and patient safety indicators.

Conclusion

This study shows that nurse handover practices at the Emergency Department of Buleleng Regional General Hospital have been carried out as a routine part of shift

changes through the use of verbal communication, medical records, handover logs, and report books. However, the implementation has not been entirely consistent when patient numbers increase simultaneously. During periods of high patient volume, clinical information tends to be conveyed more briefly, bedside validation is inconsistent, patient family involvement remains limited, and handover documentation is not always complete. These findings underscore that handover in the emergency department is not merely a task-transfer activity but a critical clinical process that determines the continuity of care and patient safety. Therefore, handover practices in the ED need to be strengthened through structured communication, concise documentation based on information priorities, selective validation for patients where possible, proportional involvement of patients' families, and more adaptive procedures specifically designed to address mass influx situations.

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