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Bedside Handover and Nursing Care Outcomes in Selected Private Hospitals

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Abstract

Effective nursing handover is essential to continuity of care, patient safety, and accurate clinical communication, yet bedside handover remains inconsistently implemented because of workload, interruptions, privacy concerns, and differences in institutional practice. This study examined bedside handover practices and their relationship with perceived nursing care outcomes in selected private hospitals in Batangas. A convergent parallel mixed-methods design was employed. Quantitative data were obtained from 130 full-time registered nurses using a researcher-developed and expert-validated questionnaire, while qualitative data were drawn from open-ended responses provided by 20 nurses. Descriptive statistics, Spearman's rank-order correlation, and thematic analysis were used. Respondents reported a high level of bedside handover practice ($M = 4.54$) and favorable overall nursing care outcomes ($M = 4.64$). Patient safety practices and communication effectiveness obtained the highest means ($M = 4.71$ each), followed by quality of nursing care ($M = 4.60$) and continuity of care ($M = 4.55$). Bedside handover practices were significantly related to quality of nursing care ($\rho = .589$), patient safety practices ($\rho = .548$), continuity of care ($\rho = .539$), and communication effectiveness ($\rho = .407$), with all relationships significant at $p < .001$. Nurses valued real-time verification, continuity, situational awareness, and patient involvement, but identified time pressure, interruptions, privacy concerns, communication barriers, and inconsistent ISBAR use as constraints. The findings indicate that structured bedside handover is associated with favorable nursing care outcomes but requires consistent institutional support, protected handover time, training, privacy safeguards, verification procedures, and compliance monitoring.

Keywords: *bedside handover; nursing care outcomes; patient safety; communication effectiveness; continuity of care; private hospitals*

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1. Introduction

Effective communication is fundamental to safe and coordinated nursing care. During every shift transition, responsibility for patients is transferred from outgoing to incoming nurses together with critical information concerning clinical status, medications, treatments, diagnostic findings, immediate risks, and ongoing care plans. Nursing handover is therefore not merely an administrative routine but a clinical process that supports continuity, accountability, and informed decision-making. Incomplete, inaccurate, or poorly organized handovers may contribute to delayed interventions, medication errors, overlooked changes in patient condition, duplication of procedures, and other adverse care outcomes (Suraya et al., 2024; Köse Tosunöz & Aydınli, 2025).

The quality of handover communication depends on both the content transmitted and the manner in which the exchange is conducted. Unstructured reporting may result in the omission of essential information, particularly when nurses work under time pressure, manage multiple patients, or experience interruptions during shift changes. Standardized frameworks such as ISBAR—Identification or Introduction, Situation, Background, Assessment, and Recommendation—are intended to reduce this variability by providing a consistent sequence for organizing patient information. However, the availability of a structured framework does not ensure consistent implementation. Institutional policy, staff preparation,

workload, documentation practices, and workplace interruptions may still influence the completeness and reliability of endorsements.

Traditionally, shift handovers have frequently been conducted at the nurses' station or in areas away from patients. Although this arrangement may permit nurses to discuss sensitive clinical matters, it excludes patients from the communication process and limits opportunities for real-time verification. Nursing-station handovers may also be interrupted by telephone calls, alarms, staff inquiries, and competing clinical responsibilities. When the patient is absent, nurses may be unable to immediately confirm identification details, examine intravenous lines and equipment, review current medications, or clarify discrepancies between written documentation and the patient's actual condition.

Bedside handover has emerged as a more patient-centered alternative. It involves the transfer of responsibility and relevant clinical information in the presence of the patient, allowing incoming and outgoing nurses to verify information, inspect the immediate care environment, and involve the patient in appropriate aspects of care. Previous research has associated bedside handover with improved patient understanding, satisfaction, communication accuracy, and nurse–patient relationships (Ghosh et al., 2025). Nevertheless, implementation remains uneven because of confidentiality concerns, time management, patient and family participation, and the absence of standardized institutional guidelines (Abt et al., 2026).

These competing considerations indicate that bedside handover cannot be evaluated solely as a communication technique. Its effectiveness also depends on the organizational conditions under which nurses work, the consistency with which structured procedures are followed, and the manner in which privacy and patient participation are managed. A bedside exchange may strengthen transparency and verification, but it may become fragmented when staffing is inadequate, interruptions are frequent, or nurses are uncertain about what information may be discussed in shared rooms. Examining nurses' actual practices and experiences is therefore necessary to understand both the perceived benefits of bedside handover and the barriers that limit its consistent application.

The study was anchored primarily in Donabedian's structure–process–outcome model of healthcare quality. In this framework, structure refers to the characteristics and resources of the healthcare setting; process refers to the activities through which care is delivered, including bedside handover; and outcomes refer to the resulting conditions or assessments of care quality (Donabedian, 1988). In the present study, the relevant perceived outcomes were continuity of care, patient safety practices, communication effectiveness, and quality of nursing care. The framework provides a logical basis for examining whether variations in the bedside handover process are associated with variations in perceived nursing care outcomes.

Although international evidence has examined bedside handover in different clinical environments, evidence from the Philippine private-hospital context remains limited. Healthcare institutions differ in staffing arrangements, documentation systems, communication culture, physical facilities, and policies governing patient participation and confidentiality. Findings obtained from large public hospitals or healthcare systems outside the Philippines may not fully represent the circumstances of nurses working in private hospitals in Batangas. Locally grounded evidence is needed to determine how bedside handover is practiced, how nurses perceive its relationship with care delivery, and what organizational constraints influence its implementation.

The present study addressed this contextual gap by examining bedside handover practices and perceived nursing care outcomes among nurses in selected private hospitals. In addition to measuring the level of the principal variables and their statistical relationships, the study incorporated nurses' experiences and challenges to provide contextual explanations for the quantitative findings.

Objectives of the Study

This study aimed to examine bedside handover practices and their relationship with perceived nursing care outcomes in selected private hospitals. Specifically, it sought to:

1. describe the demographic profile of the nurse respondents in terms of age, sex, hospital position, and length of hospital experience;
2. assess the level of bedside handover practices among nurses;
3. determine the level of perceived nursing care outcomes in terms of continuity of care, patient safety practices, communication effectiveness, and quality of nursing care;
4. examine the significant relationship between bedside handover practices and perceived nursing care outcomes;

5. explore nurses' experiences and challenges concerning bedside handover practices; and
6. derive implications and propose evidence-based measures to strengthen bedside handover practices and nursing care outcomes in private-hospital settings.

2. Review of Related Literature

2.1 Structured Bedside Handover and Clinical Communication

Nursing handover is a critical communication process through which responsibility, accountability, and essential patient information are transferred between outgoing and incoming nurses. Its effectiveness depends not only on the accuracy of the information exchanged but also on the consistency and organization of the reporting process. Unstructured handovers may permit omissions, ambiguity, repetition, and variation in the order and depth of information presented. These weaknesses become particularly consequential during shift changes, when nurses must rapidly communicate clinical status, medication requirements, treatment plans, diagnostic findings, and immediate care priorities.

Structured communication tools such as ISBAR have been widely used to improve the organization and completeness of nursing handovers. Burgess et al. (2020) reported that standardized frameworks improved clarity and reduced information loss by providing a uniform reporting sequence. Abbaszade et al. (2021) found that bedside handoff based on the SBAR technique improved the psychosocial, physical, and communication dimensions of nursing care. Ghosh et al. (2021) also associated structured handover protocols with improved handover performance, communication quality, and patient satisfaction.

Bedside handover strengthens this structured approach by allowing information to be communicated and verified in the patient's presence. It enables the outgoing and incoming nurses to compare verbal reports with the patient's actual condition, inspect equipment and treatment arrangements, and clarify inconsistencies in real time. Cruchinho et al. (2023) presented a protocol for a qualitative evidence synthesis examining factors that influence nurses' bedside handover practices, including transparency, participation, and contextual constraints. Electronic handover systems may further strengthen the process by improving access to current documentation and reducing dependence on incomplete paper-based summaries. Tataei et al. (2023), for example, found that electronic nursing handover was associated with improved handover quality and patient safety in intensive care settings. At the organizational level, integrated information systems improve decision quality only when data structures, staff capability, governance, and institutional priorities are aligned (Atento, Quinto, Espelita, & Castaneda, 2025).

2.2 Bedside Handover, Patient Safety, and Continuity of Care

Continuity of care requires the consistent transfer of relevant information, clinical priorities, and care responsibilities across nurses, shifts, units, and stages of treatment. It includes informational continuity, management continuity, and relational continuity. Failures in any of these dimensions may contribute to fragmented care, repeated procedures, delayed treatment, medication discrepancies, and inconsistent implementation of care plans.

Poor handover communication has repeatedly been identified as a risk to patient safety. Communication failures may result in overlooked deterioration, inaccurate medication administration, delayed physician orders, incomplete reporting of laboratory results, and duplication or omission of nursing interventions (Suraya et al., 2024; Köse Tosunöz & Aydınli, 2025). Wang et al. (2022) likewise observed that incomplete or unclear information exchange during handover can weaken teamwork and increase the risk of adverse outcomes.

Bedside handover may support continuity and safety by making information immediately verifiable. Nurses can confirm patient identity, medications, intravenous lines, treatment schedules, mobility precautions, and other care requirements before responsibility is fully transferred. Hada and Coyer (2021) reported that structured bedside handover interventions were associated with fewer falls, pressure injuries, and medication-administration errors. Khalaf (2023) similarly linked stronger handover structures with improved continuity and reduced risk during care transitions.

Evidence concerning measurable clinical outcomes is not entirely uniform. Malfait et al. (2020) found no significant differences between bedside and non-bedside handovers in outcomes such as length of stay, readmission, and adverse events. This suggests that conducting the report at the bedside does not automatically produce better clinical outcomes. Benefits may depend on fidelity to the procedure, institutional support, staff preparation, and the quality of communication itself. Bedside handover should therefore be understood as a potentially beneficial care process rather than an independently sufficient patient-safety intervention.

2.3 Patient Participation, Privacy, and Relational Care

One distinguishing feature of bedside handover is the opportunity it creates for patients to participate in discussions concerning their care. Unlike nursing-station handovers, bedside reporting allows patients to listen, clarify information, correct inaccuracies, raise concerns, and gain a better understanding of treatment plans. This participation is consistent with patient-centered care because it recognizes patients as active contributors rather than passive recipients of clinical information.

Anshasi and Almayasi (2024) found that bedside handover could strengthen partnership, professionalism, trust, and emotional engagement between nurses and patients. Ghosh et al. (2025) similarly reported that patients and families valued being informed and included in bedside discussions. Patient participation may also improve confidence in the healthcare team and facilitate shared decision-making. Olasoji et al. (2020), in the context of mental health nursing, observed that patient involvement in handover supported trust and collaborative care planning.

Patient participation is nevertheless influenced by readiness, communication style, health literacy, fatigue, anxiety, and personal preference. Some patients may prefer limited involvement, especially when they are uncomfortable, distressed, or unable to understand technical clinical language. Nurses may also hesitate to provide detailed information at the bedside when they believe that disclosure could create anxiety, prolong the handover, or interfere with workflow (Winebarger, 2022).

Confidentiality represents a particularly important concern. In shared wards and semi-private rooms, sensitive diagnoses, psychosocial matters, and personal health information may be overheard by other patients or visitors. Abt et al. (2026) and Anshasi and Almayasi (2024) identified privacy as a major implementation concern. Effective practice therefore requires a differentiated approach: routine and non-sensitive information may be discussed at the bedside, whereas confidential matters may need to be addressed privately before or after the bedside exchange. Patient preferences should also be assessed rather than assumed. Related patient-centered analytics research likewise treats patient narratives as meaningful evidence while emphasizing privacy, interpretability, and cultural sensitivity when experience is translated into organizational data (Atento, Quinto, Espelita, & San Juan, 2025).

2.4 Organizational Support, Training, and Implementation Barriers

The effectiveness of bedside handover is strongly influenced by organizational conditions. Even when nurses recognize its clinical value, implementation may be disrupted by workload, inadequate staffing, time pressure, interruptions, unclear policies, inconsistent documentation, and insufficient managerial support. These conditions affect both the completeness of the handover and the willingness of nurses to follow standardized procedures. At the wider health-system level, Philippine workforce fragility has also been linked to staffing maldistribution, retention pressures, competency gaps, and uneven digital-documentation readiness, conditions that may constrain the reliable execution of clinical communication processes (Atento, Quinto, & Espelita, 2025).

Interruptions from alarms, telephone calls, staff inquiries, patients' immediate needs, and competing clinical responsibilities can fragment the reporting process. Gungor et al. (2022) found that a structured and relatively uninterrupted environment was associated with more effective communication. Abou Hashish et al. (2023) likewise emphasized that staffing, workload, and environmental disruptions influence the accuracy and completeness of information transfer. When nurses are required to conduct handover while simultaneously responding to multiple clinical demands, even a well-designed protocol may be applied inconsistently.

Training and leadership support are therefore essential. Karakurt et al. (2023) found that nurses trained in standardized handover methods demonstrated greater organization, accuracy, and efficiency. Ahmed et al. (2025) likewise reported improvements in knowledge, communication practice, and protocol compliance following bedside handover training. Simulation-based approaches may be particularly useful because they allow nurses to practice structured reporting, patient engagement, confidentiality management, and responses to difficult handover situations in a controlled environment (Pun, 2023). Comparable systemic interdependencies have been identified in Philippine health professions education, where leadership, faculty workload, training capacity, clinical preparedness, and institutional resources jointly shape the consistent development of professional competencies (Bermido et al., 2025).

Managerial support is also necessary to sustain practice beyond initial training. Clear institutional guidelines, regular monitoring, coaching, and feedback help prevent gradual deviation from established procedures. Leadership must provide

practical conditions for compliance, including protected handover time, adequate staffing, accessible documentation, and clear rules regarding sensitive information. Without these supports, bedside handover may become dependent on individual preference rather than a consistent institutional practice.

2.5 Synthesis and Research Gap

The reviewed literature generally indicates that structured bedside handover can strengthen information exchange, real-time verification, patient participation, accountability, and continuity across nursing shifts. Standardized frameworks such as SBAR or ISBAR appear to improve the organization and completeness of reporting, while bedside participation may enhance trust and permit patients to clarify or correct information. Several studies also associate structured bedside handover with favorable safety and care outcomes (Abbaszade et al., 2021; Ghosh et al., 2021; Hada & Coyer, 2021).

The evidence is not entirely conclusive. Some studies have not identified significant differences in objective clinical indicators between bedside and non-bedside handover approaches (Malfait et al., 2020). The literature also consistently identifies privacy concerns, interruptions, time pressure, workload, inconsistent protocol use, and limited organizational support as barriers to implementation (Abt et al., 2026; Anshasi & Almayasi, 2024; Gungor et al., 2022). These findings suggest that the location of the handover alone is insufficient; outcomes depend on how the procedure is structured, supported, and adapted to the clinical context.

Most available studies were conducted outside the Philippines or in healthcare environments that may differ from private hospitals in Batangas in terms of staffing, organizational culture, documentation systems, physical facilities, and communication practices. Limited local evidence is available concerning nurses' perceptions of bedside handover and its relationship with continuity of care, patient safety practices, communication effectiveness, and quality of nursing care. The present study addressed this contextual and methodological gap by combining statistical evidence with nurses' accounts of the barriers and enabling conditions encountered in actual practice. Local evidence from a Philippine tertiary hospital further indicates that staffing, resource limitations, documentation requirements, and managerial engagement can shape the implementation of institutional quality standards (Garcia & Atento, 2026). Evidence from an adjacent organizational setting likewise associates work-environment support with collaboration, communication, and employee productivity, reinforcing the broader importance of supportive conditions for consistent professional practice (Espelita & Atento, 2026).

3. Methodology

3.1 Research Design

The study employed a convergent parallel mixed-methods design to examine bedside handover practices and perceived nursing care outcomes in selected private hospitals in Batangas. The quantitative strand used a descriptive-correlational design to determine the levels of bedside handover practices and nursing care outcomes and to examine the relationships among the measured variables. The qualitative strand explored nurses' experiences, challenges, and recommendations concerning bedside handover. Quantitative and qualitative findings were analyzed separately and subsequently integrated to provide numerical evidence and contextual explanations of bedside handover practice.

3.2 Participants and Sampling

The quantitative respondents were 130 registered nurses employed full-time in selected private hospitals. Eligible respondents were directly involved in patient care and regularly participated in shift-to-shift bedside handover. Part-time nurses and personnel serving exclusively in supervisory or administrative capacities were excluded because they were not consistently engaged in direct bedside endorsement. Purposive sampling was used to recruit nurses who met these criteria. For the qualitative strand, verbatim responses from 20 nurses with direct bedside-handover experience were analyzed to capture varied perspectives across clinical areas and levels of experience.

3.3 Research Instrument

Data were collected using a researcher-developed, self-administered questionnaire based on the study objectives and a review of literature on nursing handover, communication, continuity of care, patient safety, and nursing care quality. The first part obtained demographic information, including age, sex, hospital position, and length of hospital experience. The second part measured bedside handover practices and perceived nursing care outcomes across four dimensions: continuity of care, patient safety practices, communication effectiveness, and quality of nursing care. Responses were

recorded using a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Two negatively worded statements—one concerning information loss and another concerning confusion—were reverse-scored before the relevant composite scores were computed. The third part contained open-ended questions on implementation, perceived benefits, challenges, and recommendations.

The questionnaire underwent content validation by nursing and research experts to assess the relevance, clarity, and appropriateness of its items. It was subsequently pilot-tested among nurses who were not included in the final sample. Internal consistency was assessed using Cronbach's alpha. The coefficients were .947 for bedside handover practices, .907 for continuity of care, .823 for patient safety practices, .867 for communication effectiveness, and .891 for quality of nursing care, indicating good to excellent internal consistency across the measures.

3.4 Data-Gathering Procedure

Ethics approval and administrative permission were obtained before data collection. The pilot test was conducted first, after which necessary revisions were incorporated. Nurses who participated in the pilot test were excluded from the main study. Eligible nurses were informed of the study's purpose, procedures, voluntary nature, and confidentiality safeguards. Written informed consent was secured before questionnaires were distributed. Completed questionnaires were reviewed for completeness, encoded, and organized for analysis. The qualitative material was obtained from the open-ended component and retained in verbatim form under participant labels rather than personal names.

3.5 Data Analysis

Frequency and percentage were used to summarize the respondents' demographic characteristics. Means were computed to describe the levels of bedside handover practices and perceived nursing care outcomes. Spearman's rank-order correlation coefficient was used to examine the direction and magnitude of the relationships between bedside handover practices and each outcome dimension. Statistical significance was evaluated at the .05 level.

The qualitative responses were analyzed thematically through repeated reading, initial coding, clustering of related codes, comparison of patterned meanings, and refinement of theme labels. Credibility was supported by retaining direct participant statements and comparing accounts across clinical areas and levels of experience. Dependability was strengthened through a consistent thematic matrix and analytic decision trail, while confirmability was addressed by grounding interpretations in participants' statements. The quantitative and qualitative findings were then compared and integrated through narrative interpretation.

3.6 Ethical Considerations

The study received approval from the Lyceum of the Philippines University–Batangas Research Ethics Review Committee under RERC Code A1 2026-139. Participation was voluntary, and respondents could decline or withdraw without penalty. Informed consent was obtained from all nurse participants. No directly identifying personal information was collected, and responses were coded and reported in aggregate or through non-identifying labels. Electronic research files were stored in password-protected systems accessible only to the research team. The study involved no experimental bedside-handover intervention and did not recruit patients as research participants.

4. Results and Discussion

The quantitative findings were based on the responses of 130 registered nurses working in selected private hospitals in Batangas. The qualitative findings were derived from verbatim accounts provided by 20 nurses with direct experience of bedside handover. The presentation follows the study objectives and integrates the qualitative findings with the principal quantitative results.

4.1 Characteristics of the Respondents

The respondents represented different age groups, clinical assignments, and levels of hospital experience. The largest age group consisted of nurses aged 20–25 years (34.6%), followed by those aged 36–40 years (30.8%). Nurses aged 31–35 years constituted 15.4%, those aged 26–30 years accounted for 11.5%, and those aged 41 years and above represented 7.7%.

Female nurses comprised 53.8% of the respondents, while male nurses represented 46.2%. Ward nurses formed the largest clinical group (46.2%), followed by emergency-room nurses (23.1%), nurses from other clinical areas (15.4%), intensive-care nurses (11.5%), and operating-room nurses (3.8%).

The largest experience group consisted of nurses with six months to one year of hospital experience (26.9%). Nurses with two to three years and those with four to six years of experience each represented 23.1%. Those with less than six months and more than ten years of experience each accounted for 11.5%, while nurses with seven to ten years represented 3.8%. The profile indicates that the findings primarily reflect the perceptions of frontline nurses assigned to direct-care areas where shift-to-shift endorsements regularly occur.

4.2 Bedside Handover Practices

The respondents reported a generally high level of bedside handover practice, with an overall mean of 4.54. As presented in Table 1, the highest-rated practices involved communicating the patient's current condition and priority concerns and reporting relevant clinical background and significant events, both with means of 4.69. Confirmation of patient identity also received a high rating of 4.62. The lowest-rated indicator was the consistent conduct of bedside handover within the clinical area ($M = 4.31$), suggesting that implementation was not uniform across every unit or shift.

Table 1

Level of Bedside Handover Practices Among Nurses

Bedside handover practice	Mean	Interpretation
Bedside handover is consistently conducted in the clinical area.	4.31	Agree
A structured or standardized format is used.	4.50	Strongly agree
Patient identity is clearly confirmed at the beginning of handover.	4.62	Strongly agree
Current condition and priority concerns are clearly communicated.	4.69	Strongly agree
Relevant clinical background and significant events are included.	4.69	Strongly agree
Recent assessment findings and changes in condition are accurately communicated.	4.50	Strongly agree
Plans, pending tasks, and recommendations are endorsed to the incoming nurse.	4.50	Strongly agree
Overall	4.54	Strongly agree

Note. $n = 130$. The original scale interpreted 4.50–5.00 as strongly agree and 3.50–4.49 as agree.

The pattern indicates that the content of bedside handover was generally perceived as comprehensive when the procedure was performed. The comparatively lower rating for consistent implementation suggests that the principal weakness concerned regular application rather than nurses' understanding of what an effective handover should contain.

4.3 Perceived Nursing Care Outcomes

The respondents strongly agreed that bedside handover was associated with favorable outcomes across all four measured dimensions. As shown in Table 2, patient safety practices and communication effectiveness obtained the highest composite means of 4.71. Quality of nursing care followed with a mean of 4.60, while continuity of care obtained a mean of 4.55. The overall nursing care outcome mean was 4.64.

Table 2

Summary of Perceived Nursing Care Outcomes

Outcome dimension	Mean	Interpretation	Rank
Patient safety practices	4.71	Strongly agree	1.5
Communication effectiveness	4.71	Strongly agree	1.5
Quality of nursing care	4.60	Strongly agree	3
Continuity of care	4.55	Strongly agree	4
Overall nursing care outcomes	4.64	Strongly agree	—

Note. $n = 130$. The negatively worded continuity and communication items were reverse-scored. Their high reverse-coded means indicated that respondents generally perceived information as retained and bedside handover as non-confusing.

Continuity of Care

The continuity-of-care dimension obtained a composite mean of 4.55. Nurses strongly agreed that bedside handover supported the consistent transfer of important patient information and facilitated a smooth transition between outgoing

and incoming shifts. The reverse-scored statement concerning information loss obtained a mean of 4.62, indicating that respondents generally perceived essential information as retained during handover. The findings suggest that bedside endorsement helped the next shift understand the care already provided, the patient's current status, and the interventions that still required completion.

Patient Safety Practices

Patient safety practices obtained a composite mean of 4.71. The respondents rated the prevention of medication or treatment mistakes at 4.73 and the reduction of errors through information verification at 4.69. These findings indicate that nurses principally valued bedside handover as an opportunity to compare the verbal report, documentation, and actual patient condition before responsibility was transferred.

Communication Effectiveness

Communication effectiveness also obtained a composite mean of 4.71. Bedside handover improved communication among nurses and supported clear, organized information exchange, with both statements obtaining means of 4.73. The reverse-scored statement concerning confusion obtained a mean of 4.65, indicating that respondents generally did not perceive bedside handover as confusing. The favorable result should nevertheless be interpreted together with the qualitative findings concerning interruptions, inconsistent adherence to ISBAR, time pressure, and difficulties communicating in shared rooms.

Quality of Nursing Care

Quality of nursing care obtained a composite mean of 4.60. The highest-rated indicator was the contribution of bedside handover to overall nursing care quality ($M = 4.69$), followed by coordinated team-based care ($M = 4.62$) and increased nursing accountability ($M = 4.50$). These findings suggest that bedside handover was perceived as extending beyond information transfer because it also clarified responsibilities, care priorities, and the expected actions of the incoming nurse.

4.4 Relationship Between Bedside Handover Practices and Nursing Care Outcomes

Spearman's rank-order correlation was used to determine whether stronger bedside handover practices were associated with more favorable nursing care outcomes. Table 3 shows that all four relationships were positive and statistically significant at $p < .001$.

Table 3

Relationship Between Bedside Handover Practices and Nursing Care Outcomes

Nursing care outcome	Spearman's ρ	p value	Interpretation
Continuity of care	.539	< .001	Significant
Patient safety practices	.548	< .001	Significant
Communication effectiveness	.407	< .001	Significant
Quality of nursing care	.589	< .001	Significant

Note. $n = 130$. All correlations were significant at the .01 level.

The strongest relationship was found between bedside handover practices and quality of nursing care ($\rho = .589$), followed by patient safety practices ($\rho = .548$) and continuity of care ($\rho = .539$). Communication effectiveness had the lowest correlation ($\rho = .407$), although the relationship remained statistically significant. The results indicate that nurses who reported more organized and consistently implemented bedside handover practices also tended to report more favorable nursing care outcomes. These associations do not establish causality; rather, they show that the quality of the handover process varied systematically with nurses' assessments of care quality, safety, continuity, and communication.

4.5 Nurses' Experiences, Challenges, and Recommendations

The thematic analysis generated three major themes: the value of bedside handover, obstacles to effective implementation, and recommendations for strengthening practice. The themes and corresponding subthemes are summarized in Table 4.

Table 4*Summary of Qualitative Themes on Bedside Handover*

Theme	Subthemes	Central finding
Bedside handover value	Safety through real-time verification and reassessment; continuity, situational awareness, and patient involvement	Nurses valued bedside handover because it allowed them to verify the patient's actual condition, detect changes, maintain a shared care plan, and involve patients in appropriate discussions.
Obstacles to effective handover	Workload, time pressure, and interruptions; privacy and patient-communication barriers	Staffing constraints, competing demands, telephone calls, paging, shared rooms, and patient hearing or cognitive limitations could disrupt or restrict bedside reporting.
Recommendations to enhance practice	ISBAR standardization and staff capability; protected handover time and privacy-supportive workflow	Participants recommended standardized ISBAR procedures, training, protected handover periods, verification of pending tasks, privacy measures, and continuing monitoring.

Bedside Handover Value

The first theme concerned the clinical and relational value of bedside handover. Nurses explained that observing the patient while receiving the report enabled the incoming nurse to compare documentation with the patient's current condition. Participants described circumstances in which bedside reassessment revealed subtle changes that prompted earlier evaluation, escalation, or adjustment of the care plan. Bedside handover also supported continuity and situational awareness by allowing the next shift to continue care without reconstructing earlier information. Patient involvement was considered beneficial when it enabled patients to clarify details, understand their care plans, and feel respected during the transition.

Obstacles to Effective Handover

The second theme concerned operational and ethical barriers. Nurses identified insufficient staffing, heavy patient census, time pressure, telephone calls, alarms, paging, and other interruptions as factors that could shorten or fragment endorsement. Privacy was particularly problematic in shared rooms, where discussion of sensitive information could be overheard. Nurses also encountered patients with hearing, cognitive, or communication difficulties that limited meaningful participation. These findings indicate that departures from bedside handover may sometimes reflect efforts to preserve concentration or confidentiality rather than opposition to patient-centered care.

Recommendations to Enhance Practice

The third theme focused on standardization and organizational support. Participants recommended a common ISBAR sequence, regular staff training, simulation, coaching, post-handover verification, and monitoring of compliance. Nurses emphasized that a standardized format was especially important during busy shifts because it provided a defined sequence for essential information. Participants also proposed protected handover time to reduce non-urgent interruptions and privacy measures for shared rooms. These recommendations indicate that effective bedside handover depends on both individual competence and the institutional conditions established by hospital leadership.

4.6 Discussion

The findings demonstrate that bedside handover was already substantially practiced in the selected hospitals, particularly in communicating current conditions, priority concerns, clinical background, and significant events. Nevertheless, its comparatively lower score for consistent implementation indicates that practice may vary by unit, shift, workload, or local leadership. This distinction is important: the respondents generally endorsed the components of structured handover, but the procedure was not necessarily performed with the same regularity in every clinical setting.

The high rating for patient safety reflects the practical advantage of conducting handover where verbal information can be compared with the patient, documentation, medications, equipment, and immediate environment. The qualitative accounts strengthened this interpretation by describing real-time detection of discrepancies and changes in patient condition. This finding is consistent with Hada and Coyer (2021), who associated structured bedside handover with

reductions in falls, pressure injuries, and medication-administration errors, and with research emphasizing the role of organized handover communication in safer care transitions.

The favorable continuity-of-care findings indicate that bedside handover helped the incoming nurse understand what had been completed and what remained pending. This aligns with the informational and management dimensions of continuity discussed by Humphries (2020) and Khalaf (2023). The qualitative accounts further showed that continuity depended on a shared care plan and adequate situational awareness rather than the physical location of the report alone.

Quality of nursing care had the strongest association with bedside handover. This may be explained by the breadth of the construct. A well-conducted handover can simultaneously clarify priorities, promote coordination, support accountability, identify risks, and involve the patient. Accordingly, nurses may view bedside handover as part of the care process itself rather than merely a mechanism for transmitting information. This interpretation is consistent with the findings of Abbaszade et al. (2021) and Ghosh et al. (2021), who associated structured bedside handover with improved dimensions of nursing care, communication, and patient satisfaction.

Communication effectiveness received a high descriptive rating but had the weakest correlation with bedside handover among the four outcomes. This result may reflect the influence of factors external to the formal handover procedure. Communication can still be impaired by noise, interruptions, staffing limitations, privacy concerns, inconsistent terminology, and differences in professional confidence. The qualitative themes directly identified these conditions. Thus, placing the handover at the bedside does not automatically remove communication barriers; the procedure must also be protected, standardized, and supported.

The results further indicate that patient involvement is beneficial but must remain context-sensitive. Patients may contribute corrections, questions, and information, but not every patient is equally able or willing to participate. Confidentiality also limits what may appropriately be discussed in shared rooms. These findings support the balanced approach described by Anshasi and Almayasi (2024): routine information may be communicated at the bedside, whereas sensitive matters may require a private discussion.

Viewed through the Donabedian model, bedside handover represents a care process whose effectiveness depends on structural support. Staffing, training, physical space, documentation systems, privacy resources, and managerial monitoring constitute structural conditions that influence the quality of the process. The positive relationships with nursing care outcomes are therefore best interpreted as evidence that a well-supported handover process is associated with better perceived outcomes. They should not be interpreted as proof that simply relocating endorsement to the bedside will independently improve care.

Overall, the quantitative and qualitative findings converge. Nurses perceived bedside handover as beneficial for safety, continuity, communication, and quality while also identifying organizational conditions that could weaken implementation. The findings support a structured but adaptable bedside handover model incorporating ISBAR, protected handover time, real-time verification, patient-sensitive communication, privacy safeguards, continuing training, and institutional monitoring.

The findings should be interpreted within the study's limitations. The quantitative results were based on nurses' self-reported perceptions rather than direct observation or objective patient outcomes. The correlational design does not support causal inference. The selected private-hospital setting limits generalization to public hospitals or institutions in other regions, and the qualitative strand was based on a relatively small purposive group. Future studies should combine observed handover fidelity with objective safety and care indicators.

5. Conclusions, Recommendations, and Implications

5.1 Conclusions

The study examined bedside handover practices and their relationship with perceived nursing care outcomes among registered nurses in selected private hospitals in Batangas. The sample was composed largely of frontline nurses working in ward and emergency-care settings, and the findings primarily reflect personnel regularly involved in direct patient care and shift-to-shift endorsement.

Bedside handover was strongly practiced, particularly in confirming patient identity, communicating the patient's current condition and priority concerns, presenting relevant clinical background, reporting recent assessment findings, and

endorsing pending interventions and recommendations. The comparatively lower rating for consistent conduct across clinical areas indicates, however, that implementation may vary according to unit conditions, workload, staffing, and local practices.

The respondents reported favorable nursing care outcomes in all measured dimensions. Patient safety practices and communication effectiveness received the highest assessments, followed by quality of nursing care and continuity of care. The reverse-scored items further indicated that respondents generally perceived essential information as retained and bedside handover as non-confusing.

Bedside handover practices were positively and significantly associated with continuity of care, patient safety practices, communication effectiveness, and quality of nursing care. The strongest relationship was observed with quality of nursing care, followed by patient safety practices and continuity of care. These findings indicate association rather than causation.

The qualitative findings clarified the statistical relationships. Nurses valued bedside handover because it enabled real-time reassessment, verification of information, recognition of changes in patient condition, shared situational awareness, continuity of the care plan, and appropriate patient participation. At the same time, workload, insufficient staffing, time pressure, interruptions, privacy concerns, patient communication limitations, and inconsistent use of ISBAR could weaken the procedure.

Overall, bedside handover should not be understood simply as transferring endorsement from the nurses' station to the patient's bedside. Its effectiveness depends on the quality, consistency, structure, and organizational support surrounding the process. A standardized but adaptable handover system—supported by protected time, competent staff, accurate documentation, patient-sensitive communication, privacy safeguards, and continuing monitoring—may contribute to more favorable nursing care outcomes in private-hospital settings.

5.2 Recommendations

- **Institutionalize a standardized bedside handover protocol.** Participating hospitals should adopt a common ISBAR-based structure that includes patient identification, current clinical status, relevant background, latest assessment findings, safety concerns, pending interventions, and recommendations for the incoming shift.
- **Provide protected handover time.** Nursing administrators should establish designated periods during shift changes in which non-urgent telephone calls, routine inquiries, and avoidable interruptions are minimized.
- **Strengthen staff preparation and continuing competency.** Hospitals should conduct orientation, refresher courses, coaching, and simulation-based activities on ISBAR, real-time bedside verification, patient engagement, clinical escalation, and management of family participation.
- **Establish privacy-sensitive handover procedures.** Routine and non-sensitive information may be discussed at the bedside, whereas confidential diagnoses, psychosocial concerns, and other sensitive matters should be communicated privately. Practical measures may include portable screens, appropriate room arrangements, lower voice levels, and clear disclosure guidance.
- **Require real-time verification and closure of pending responsibilities.** The incoming and outgoing nurses should jointly verify patient identity, medications, intravenous therapies, equipment, immediate safety risks, and significant changes in condition. Pending tests, treatments, referrals, and physician instructions should be explicitly acknowledged before responsibility is transferred.
- **Monitor implementation through audit and feedback.** Nurse supervisors and unit leaders should periodically assess compliance with the bedside handover protocol, identify recurring omissions or interruptions, and provide developmental feedback.
- **Pilot an ISBAR-based bedside handover enhancement program.** The program may be implemented initially in selected units and evaluated using compliance audits, staff feedback, communication indicators, incident reports, and available patient-safety measures before hospital-wide adoption.
- **Extend subsequent research beyond self-reported perceptions.** Future studies should include a wider range of hospitals, direct observation of handover practices, pre- and post-implementation evaluation, and objective indicators such as medication errors, omitted care, falls, escalation delays, and reported communication incidents.

5.3 Implications of the Study

Practical and Clinical Implications

The findings position bedside handover as a clinical safety and continuity process rather than a routine administrative exchange. Its practical value lies in enabling outgoing and incoming nurses to compare verbal reports with the patient's actual condition, documentation, medications, equipment, and immediate environment. Hospitals should therefore integrate bedside handover into patient-safety and quality-improvement systems rather than leave implementation to individual nursing preference.

Institutional and Managerial Implications

The results support the structure–process–outcome relationship proposed in the Donabedian model. Bedside handover represents the care process, but its quality depends on structural conditions such as staffing, leadership support, communication protocols, physical space, documentation systems, and training. Nursing managers must therefore address the environment surrounding handover, not merely instruct nurses to perform it at the bedside.

Educational Implications

Bedside handover requires competencies in clinical communication, prioritization, reassessment, confidentiality, patient engagement, and teamwork. Nursing education and hospital training programs should include scenario-based practice reflecting actual conditions, including deteriorating patients, incomplete documentation, interruptions, shared rooms, family observers, and patients with communication limitations.

Scholarly and Methodological Implications

The study contributes mixed-methods evidence from private hospitals in Batangas, a setting that remains underrepresented in bedside handover research. The integration of statistical relationships with nurses' accounts demonstrates that high overall ratings may coexist with practical implementation barriers. Because the quantitative findings were based on nurses' perceptions and a correlational design, broader multicenter and observational studies are needed to establish external validity and clinical effectiveness.

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