

Appendix B. Characteristics of the included studies

Study	Setting	Department	Design	Target	Intervention	Patient outcome
Haig (2006)	OSF St. Joseph Medical Centre Bloomington, Illinois, U.S.	All	BAS	Communication between clinicians (in verbal and written form)	Educational program: all clinical staff	1. Adverse patient events 2. Adverse drug events
Christie (2009)	South Devon Healthcare Foundation Trust, Tobay, United Kingdom	All	BAS	Patient hand-off	Educational program: all clinical staff	1. Hospital mortality 2. Adverse events 3. Cardiac arrests
Andreoli (2010)	Toronto Rehabilitation Institute, University of Toronto, Canada	Geriatric & musculo. rehabilitation	BAS	Team communication (prevention of falls and management)	Educational program: all clinical/non-clinical staff & unit leaders	1. Incidence of Falls 2. Severity of falls (categorized in 4 levels: no harm, minor, moderate, major)
Field (2011)	Nursing homes (n=26), State of Connecticut, U.S.	-	RCT	Telephone communication between nurses and physicians anticoagulation management)	Educational program: all nursing staff	1. INR values within the target range 2. Preventable adverse events related to warfarin-therapy
Freitag (2011)	Rush Oak Park hospital, Oak Park, Illinois, U.S.	All	BAS	Nursing hand-off (between shifts and units)	Interactive teaching: nursing staff, patient care technicians	1. Inpatient Fall Rate 2. Restrained Patients Rate 3. Catheter Associated UTI Rate
Telem (2011)	The Mount Sinai Hospital, New York, NY State, U.S.	Surgery	CCT	Physician hand-off (trained general surgery vs. untrained subspecialty surgery residents (n=20)	Interactive teaching: residents, subspecialty residents as controls	Sentinel event (unexpected occurrence involving death or serious physical or psychological injury or the risk thereof and necessitating immediate investigation)
De Meester (2013)	Antwerp University Hospital, Antwerp, Belgium	All	BAS	Nursing hand-off (between shifts), Communication: deteriorating patients (nurses calling physicians)	Interactive teaching	Serious adverse event (=unexpected occurrence involving death or ICU admission or call of the cardiac arrest team)

Randmaa (2014)	Country Council of Gävleborg, Sweden (University of Gävle)	Anesthesiol.	CCT	Communication in hospital (priority: physician and nurse hand-off)	Interactive teaching	Adverse events with communication failure as a root cause
Jarboe (2015)	Nursing centre and rehabilitation facility (n.s.), southern Maryland, U.S.	-	BAS	Communication between nurses and physicians (in notifying providers of change in resident status)	Educational session, integration into competency training	1. Transfers to acute care hospitals 2. Types of transfers by clinical condition 3. Transfers resulting in hospitalisation
Pineda (2015)	New Jersey hospital (n.s.),	Medico-surgical	BAS	Nursing hand-off	Educational session	Patient falls
Devereaux (2016)	Nursing/post-acute care facility (n.s.), performed by University of Pittsburgh, Pennsylvania, U.S.	-	BAS	Communication between nurses and physicians (in notifying providers of change in patient status)	Introduction of condition-specific SBAR	1. Transfers to hospital 2. Hospitalisations 3. 30-day readmissions

Abbreviations: BAS: Before-After-Study, CCT: Clinical Controlled Trial, CIRS: Critical Incident Reporting System, ICU: Intensive Care Unit, INR: International Normalised Ratio, MRSA: Methicillin-Resistant *Staphylococcus aureus*, n: number, n.s.: not specified, RCT: Randomised-Controlled Trial, SBAR: Subject Background Assessment Recommendation, U.S.: Unites States of America; UTI, Urinary Tract Infection.