Appendix D. Details of the results

Objective/ Study	Patient outcome (PO)	PO collection	Duration of PO measurement	Results detail
Team communication in gerneral				
Haig (2006)	Adverse patient events Adverse drug events	Retrospective chart review (each month 20 randomly selected charts)	Pre: 1m Post: 12m	Decrease: 90 to 49 per 1,000 patient days[#] Decrease: Events from 30 to 18 per 1,000 patient days[#]
Andreoli (2010)	Falls incidence Falls severity (4 levels) Near-miss reporting	Retrospective chart review + "safety reporting" (by an online reporting system)	n.r.	Total falls showed an increasing trend on the study teams[#] Decreasing trend across major falls (4 vs. 2) both the organization and the study units[#] Decreasing trend across both the organization and the study units[#]
Patient hand-off – nurses				
Freitag (2011)	Inpatient Fall Rate Restrained Patients Rate Catheter Associated UTI	Retrospective chart review	n.r.	Reduction of 5%[#] Reduction of 31%[#] Reduction of 34%[#]
Pineda (2015)	Patient falls	n.s.	Pre: 1m Post: 1m	2 falls (pre) vs. 0 falls (post)[#]
Patient hand-off – physician				
Telem (2011)	Sentinel events	Morbidity and mortality surgical database and hospital performance improvement initiative	Pre: 1m Post: 1m	No statistical significant difference in sentinel events, general surgical vs. surgical subspecialty interns (one sentinel event)
Patient hand-off – physician and nurses				
Randmaa (2014)	CIRS events (communication errors)	Prospective analysis of "safety reports" (=CIRS)	Pre: 12m Post: 12m	Decrease from 31% to 11%, $p<0.0001$
Christie (2009)	Hospital mortality Adverse events Cardiac arrests MRSA bacteraemias	n.s.	n.r.	11% reduction in hospital mortality[#] 65% reduction of adverse events[#] 8% reduction of cardiac arrests[#] 83% reduction of MRSA bacteraemia[#]

Telephone communication from nurse to doctor – anticoagulation management				
Field (2011)	INR values within the target range (2.0 - 3.0) Preventable AE related to warfarin-therapy	Quarterly reviews of nursing home records by pairs of physician-reviewers	55,167 resident days (intervention homes) vs. 53,601 (control)	4.5% more time in the therapeutic range than in control homes (95% CI: 0.3%-8.7%) Statistically non-significant reduction, odds ratio 0.9 (95% CI: 0.5-1.4)
Telephone communication from nurse to doctor – Deteriorating/status change of a patient				
De Meester (2013)*	Unexpected death ICU admission Call of cardiac arrest team	Retrospective analysis of medical records and internal emergency calls (performed by a trained expert)	Pre: 10m Post: 10m	Significant decrease from 0.99 to 0.34/1000 admissions (RRR = −227%, 95% CI = −793 to −20; p < 0.001) Significant increase from 13.1 to 14.8/1000 admissions (RRR = 50%, 95% CI: 30-64%, p=0.001) No significant difference (p>0.05)
Jarboe (2015)	Transfers to acute care hospitals Types of transfers by clinical condition criteria Transfers resulting in hospitalization	n.s.	Pre: 12m Post: 8m	No significant difference (p = 0.482) No significant difference in i) preventable transfer group, p=0.927 or ii) emergent transfer group, p=0.565 No significant difference (p = 0.662)
Devereaux (2016)	30-day readmissions Transfers to hospital Avoidable hospitalisations	n.s.	Pre: 3m Post: 3m	Significant reduction, 0.12 vs. 0.04, p=0.012 Significant reduction, 0.44 vs. 0.24, p<0.001 Significant reduction, 0.15 vs. 0.05, p=0.007

Abbreviations: CI, confidence interval, month(s), ICU: Intermediate Care Unit, n: number, n.r.: not reported, pre/post: duration of outcome measurement pre/post intervention, RRR: Relative Risk Reduction, SBAR: Subject Background Assessment Recommendation, vs.: versus