Evidence-Based Practice Project:
Implementing Bedside Nursing Handover

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August 18, 2017
I. Introduction

The purpose of this project is to implement a change in the critical care unit’s nursing handover process that will establish a unit policy of mandatory bedside nursing handover. Currently there is no standardized protocol or unit policy that regulates the nursing handover process which results in inconsistency, poor communication, poor relations amongst staff, and dissatisfaction amongst patients and their families. Adopting this new policy will provide the opportunity to promote unity amongst staff, support patient-centered care, maintain safe communication practices, and have a more efficiently run unit. This paper will present evidence from nursing literature that supports this change as well as recommendations from the project coordinator on ways to effectively implement the new policy.

II. Problem Identification

Nursing handover is a process in which there is a transition of patient care, and an exchange of information between caregivers regarding the patient’s condition, plan of care, and relevant information needed to appropriately care for patients during the shift (Lamond, 2000). Since research has linked many sentinel events and adverse patient outcomes in hospitals to communication problems, nursing handover has been examined and explored for potential ways to improve its efficiency (McMurray, 2010). Joint Commission has adopted the improvement of nursing handover processes as one of their national patient safety goals. Their recommendations include standardizing nursing handover and implementing strategies that allow nursing handover to be up-to-date, interactive, and have minimal interruptions (Triplett, 2011).

Historically, nursing handover has been given in hospitals using a variety of methods including verbal, written, and tape recorded. These methods have been associated with providing information that is inaccurate, unreliable, outdated, and irrelevant. In addition these methods are
either too time consuming, fail to give nurses the opportunity to ask or respond to questions, or have a high potential for interruptions. These handover methods also leave patients without access to care during the handover process which can range anywhere from 30-45 minutes during change of shift (Trossman, 2009).

III. Importance of the Problem

Nursing handover is a common part of nursing practice that is fundamental to safe patient care. Miscommunication during nursing handover can lead to inappropriate service discontinuities, suboptimal patient flow through the system, readmissions, duplication of services and patient dissatisfaction. Handover processes can be confined to ritualistic, retrospective, treatment-oriented information rather than being patient-centered and providing focus and direction for forward planning. Without supporting documentation, verbal and tapped handovers create unnecessary risk, while written fails to provide official information (Caruso, 2007).

IV. Description of the Solution/Recommendation

Patient input reduces miscommunication, adverse events, duplication of services, and enhances satisfaction and continuity of care, thus bedside nursing handover is recommended as a solution. Implementing this method will comply with Joint Commission recommendations, shorten the length of time that patients are left unsupervised, minimize communication errors, and provide consistency leading to better patient and staff satisfaction (Trossman, 2009). The new bedside handover method can also be enhanced with the use of a standard written report sheet nurses can use to facilitate the process. The sheet will contain required information that should be discussed during the handover, and then left with the oncoming nurse for reference during the shift. During the report, patients will have the opportunity to ask questions, provide input, and suggest any changes they feel necessary. The patient will also have the option to include their family members in the report.
The nursing handoff report sheet should be structured in a SBAR format and include important information regarding the patient’s reason for admission, past medical history, shift assessment, attending physician, consults, family contacts, allergies, pain management, diet, activity, invasive devices, IV fluids, active medications, mobility, cultural considerations, labs and diagnostic studies, problems that occurred within the shift, and plan of care. The patient and family should be involved in the shift report and allowed to ask questions and make requests. At the end of the shift report, there should be a chart review by the current shift nurse and oncoming nurse to review orders in the EMR and/or paper chart, and each nurse should sign off when report is completed. This process will ensure that all elements of the report are completed.

V. Literature Review

Weaknesses in verbal and written nursing handover processes were examined through a pilot study in the UK. This study found that there was significant data lost during verbal report due to nurses providing information from memory while the receiving nurse takes notes. Written report was associated with lost data related to imperative information that was not included on the report sheet or not filled in completely by the off-going nurse. These study results are consistent with previous literature that suggests that both verbal and written nursing handover allow for potential miscommunication as well as incomplete information (Pothier, Monteiro, Mooktiar & Shaw, 2005).

Caruso (2007) discussed the benefits of bedside nursing handover when it was implemented on a hospital’s medical-surgical and cardiology units. The study found that bedside nursing handover resulted in the patients feeling empowered. Furthermore the patients were able to serve as an additional resource in diagnosis and treatment, allowing them to feel more involved in their
care. Patients reported that bedside handover made them feel safe and strengthened their relationship with the nurses. McMurray et al (2010) also addressed the benefits of nursing handover based on a study conducted in two acute care hospitals in Australia. These hospitals switched from verbal nursing handover to a standardized beside handover. Based on observations and interviews from the staff, the study found that nursing handover provided opportunities for patient teaching and allowed patients and families to see the importance of the handover process (McMurray, 2010).

Triplett et al (2011) discussed the benefits of beside nursing handover when the process was consistently implemented within critical care and progressive care units in a regional hospital in Minnesota. The hospital used bedside nursing handover with a standardized check-off sheet developed by staff members to ensure that the report was given consistently and covered specific elements. One year after the policy was implemented, Triplett’s study found that there were better relationships among the staff members, increase patient awareness of their condition and plan of care, and improved educational opportunities for the staff when using unfamiliar equipment. The results of this study were obtained from in depth interviews from staff nurses (Triplett et al, 2011). Trossman (2009) also reported findings from a children’s hospital in Indianapolis that implemented bedside nursing handover. Surveys from this study revealed overwhelming positive reviews from the staff, patients, and family members as well as improved safety within the hospital. The process also helped patients and families feel more comfortable when there was a change of caregivers (Trossman, 2009).

Cahill et al (1998) examined patient perceptions of beside nursing handover through grounded theory research and discovered a few pitfalls. One area of concern was that some patients did not feel as if they were included in the bedside report due to the distance the nurses
kept themselves at while conducting the report, (such as standing right at the doorway rather than inside the room) lack of eye contact with the clients, and lack of inclusion of the client within the conversation. Another area of concern was that although some patients may have been encouraged to participate, they felt uncertain of their role, too shy or afraid to give input, or were simply too ill to take an active role (Cahill, 1998). Although the later cannot be avoided, the safety and communication benefits of bedside nursing handover still present multiple benefits. The concerns related to helping the client feel involved can be addressed with appropriate training of the staff on the correct procedures, how to make the patients comfortable, and how to encourage involvement. Additionally educating patients on the bedside handover process both on admission as well as throughout the shift can give patients the opportunity to get used to the idea and become more aware of how the process should work.

VI. Costs

Costs to initiate the new policy for bedside handover will be minimal and limited to staff training and printing expenses. The staff training will take place as unit based meetings outside of work hours. Printing costs will be associated with the handoff sheet to be used by nurses during report, printing of an official copy of the policy to be added to the unit’s policy and procedures manual, and printing of the patient education sheet that explains bedside handover to be provided to patients upon admission. Anticipated cost savings related to decreased errors and increased productivity that are likely to result from the switch to bedside nursing handover could potentially wipe out these costs to the unit. This also has potential to decrease costs to patients by eliminating communication errors that previously led to duplication or unnecessary services (Caruso, 2007).
VII. Safety

Overall safety on the unit is likely to improve with implementation of the new bedside handover policy as it has on various other units that have adopted the policy. The once 30-45 minute time frame patients had to wait before being able to see and meet their nurse during change of shift will significantly be reduced. Two nurses will be able to verify the patient’s safety at change of shift and visually confirm all of the important elements such as medication infusions, invasive lines, neurological status etc. This will reduce discrepancies in patient assessments between nurses and serve as a double checking system. Implementing a standardized bedside shift report reduces the potential for errors related to omitted information or missed communication (Trossman, 2009).

VIII. Feasibility of Implementing the Change

There are many challenges that may present as obstacles at first when planning to implement bedside reporting on the unit. The biggest obstacle anticipated is resistance from staff regarding implementing the change. This obstacle can be best addressed by involving the staff in the process and giving them the opportunity to make suggestions and changes to the procedure. Timeframe and structure may also be a challenge initially as staff members, patients, and families orient themselves to the new procedure, which could potentially result in a lengthier process. These obstacles are relatively minor and can be easily overcome with careful planning. The high success rates that bedside nursing handover has generated in various hospitals in a variety of settings across the globe supports the ability for the policy to be implemented successfully (Pepper, 1978).

IX. Project Objectives
With the implementation of the new bedside nursing handover policy, there will be a goal of achieving the following outcomes: critical care unit patients and families will report 90% satisfaction with the new bedside nursing handover method as evidenced by surveys, 90% of critical care patients and families will report that the new bedside reporting system is interactive and patient-centered as evidenced by surveys, 90% of staff nurses will report decreased interruptions after implementation of bedside handoff as evidenced by surveys, and 90% of staff nurses will report a reduction in miscommunication related to handoff after implementing beside report as evidenced by surveys. Achieving these goals will allow the staff members to see the positive impact of implementing bedside nursing on the unit.

X. Communication and Implementation Plan

To begin the implementation process of bedside handover, a nursing committee will be organized on the unit for the development of the standardized nursing handoff sheet. Once all items to be included are agreed upon by the committee, two volunteers will be recruited to design a handoff sheet. The sheets will be submitted to the unit manager for approval and voted upon by the nursing staff. Once the handoff sheet is finalized the new reporting system will be implemented with a pilot period in which half of the nurses on the unit will be required to use the bedside method while the remaining nurses will continue their old method. The pilot period will be conducted over two weeks and all nurses will get the opportunity to try out the bedside method. Staff nurses will then be able to provide feedback on the bedside nursing method and make any suggestions. The committee will meet again to finalize the final policy and set a date for full implementation of the new handover process. Once finalized the staff will be made aware of the official date of change via a staff meeting, e-mail, and with various flyer reminders posted.
around the unit. Clients and families will be made aware by written education material upon admission.

XI. Conclusion

Nursing handover is a common and integral procedure that occurs every day. The importance of ensuring its efficiency, consistency, and accuracy, it is imperative to examine processes that are weak and implement strong strategies that allow for better communication. Although many units do not employ bedside nursing handover and there are various methods continuing to be used globally by nurses, the research supporting bedside nursing handover is both promising and encouraging. Thus moving toward and patient-centered handover method such as this one is recommended in order to obtain the most optimal patient outcomes as well as satisfaction.
References


Pepper, G. A. (1978). BEDSIDE REPORT: WOULD IT WORK FOR YOU?. *Nursing, 8*(6),