



Bedside Handover; Standard Operating Protocols”

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Research Aims

To describe bedside handover in nursing in terms of:

1. Structures;
2. Processes;
3. Outcomes.

Expected Outcome

- Development of a toolkit of standard operating protocols (SOPs) that can be used by wards wanting to implement bedside handover.

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Method

- Research Design:
 - Case study with nested 'cases' at each site (i.e each ward).
- Sample:
 - 6 wards in 2 Australian hospitals (Qld and WA)
- Data Collection:
 - Observation of bedside handover for 5 days in each ward
 - In-depth interviews with various nursing staff
 - Clinical indicator data on medication errors, pressure ulcers, and falls 16 months prior to and 16 months after bedside handover implemented.





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- Data Analysis:
 - Descriptive statistics (SPSS)
 - Thematic content analysis
 - Statistical process control charts (P charts)
- Ethics Approval:
 - Two universities and two hospitals approved this study
 - Consent was obtained from all participants





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Results





- 532 bedside handovers were observed
- Average length of handover 1 minute 16 seconds (± 51 sec)
- 34 in-depth interviews were conducted

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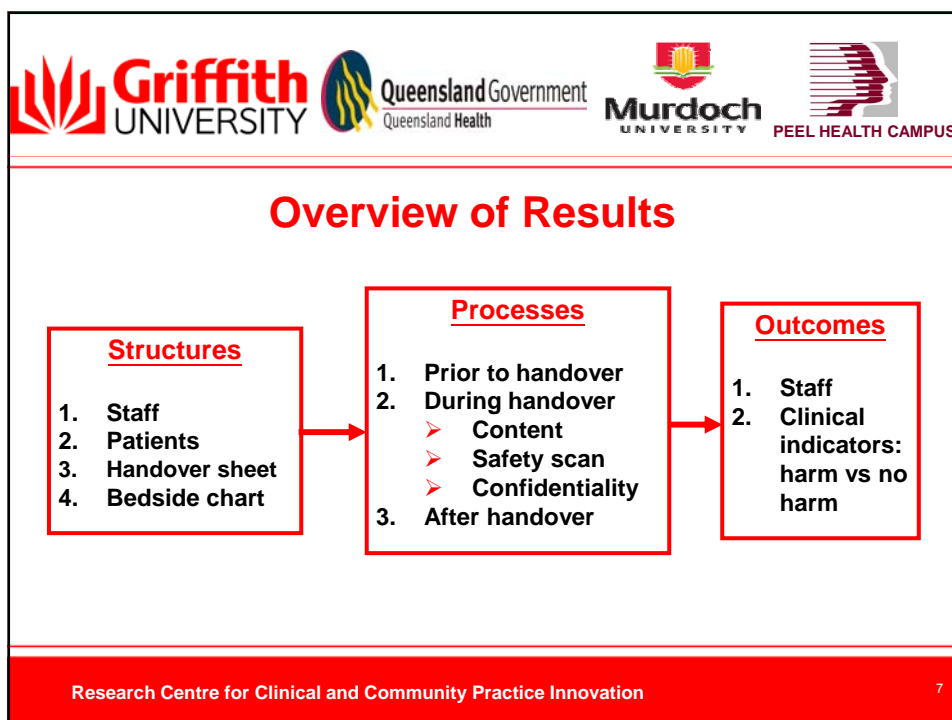









Observations	Hospital A Frequency (%) N = 263	Hospital B Frequency (%) N = 269	Total Frequency (%) N = 532
Type of Ward			
Medical	186 (71%)	103 (38%)	289 (54%)
Surgical	N/A	93 (35%)	93 (17%)
Combined	N/A	73 (27%)	73 (14%)
Rehabilitation	77 (29%)	N/A	77 (14%)
Report Content (SBAR)			
Situation	171 (65%)	Not used	N/A
Background	148 (56%)		
Assessment	118 (45%)		
Recommendations	156 (59%)		
Active patient involvement	85 (32%)	154 (57%)	239 (45%)
	Mean (\pmSD)	Mean (\pmSD)	Mean (\pmSD)
# of staff at the bedside	4.0 (1 ± 2.3)	3.7 (1 ± 1.17)	3.8 (1 ± 1.2)
Time for Handover (sec)	119 (0 ± 7.8)	120 (0 ± 0.95)	76 (± 51) sec





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Interview Participants			
Characteristic	Hospital A N = 15	Hospital B N = 19	Total N = 34
EN	4 (27%)	3 (16%)	7 (21%)
Level 1	8 (53%)	7 (37%)	15 (44%)
Level 2	3 (20%)	4 (21%)	7 (21%)
NUM	0	5 (26%)	5 (15%)
Full-time	10 (67%)	6 (32%)	16 (47%)
Female	15 (100%)	17 (90%)	32 (94%)

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Structures	
Staff	<ul style="list-style-type: none"> •2-3 teams per ward with H/O given in each team •Team leader of outgoing team and all oncoming team members •Shift coordinator attends 1 team H/O then gets short report from other team leaders
Patients	<ul style="list-style-type: none"> •Condition may limit participation (asleep, ↓LOC, isolation)
Handover sheet	Computer generated and updated each shift Contains pt history (+ social), discharge planning, changes in condition; other priority information, sensitive information
Bedside chart	Observation record, medication record, fluid balance, risk assessments (falls, pressure ulcers)
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Processes – Prior to Handover	
<ul style="list-style-type: none"> • Patient allocation completed by outgoing charge nurse. • Handover sheet contains information on all patients on the ward; updated each shift and copies made for oncoming staff. • Patient informed that bedside handover will start shortly. • Families may stay for the handover with the patients' consent. • Visitors asked to wait in the 'lounge' or other waiting area. 	
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Processes – During Handover

- Outgoing staff introduce patient to oncoming staff.
- Content: reason for admission, history, tests, treatments, ADL, nursing care plan, changes in patient condition, pending tests or specimens.
- SBAR used when patients are less known to staff.
- Safety Scan: patient (visual check), environment (equipment, lines), bedside chart (observation and medication record, risk assessments).
- Patients invited to comment or ask questions.
- Patients presence prompts other key issues to be discussed.
- Confidential/sensitive information on the handover sheet or shared away from patients and visitors.

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Processes – After Handover

- Team leaders give the charge nurse a short handover if the charge nurse did not attend the bedside handover.
- Handover sheet is key component of this handover.
- Staff who start 'between handovers' join teams, using the handover sheet as a guide for tasks to be undertaken under the directions of the team leader.

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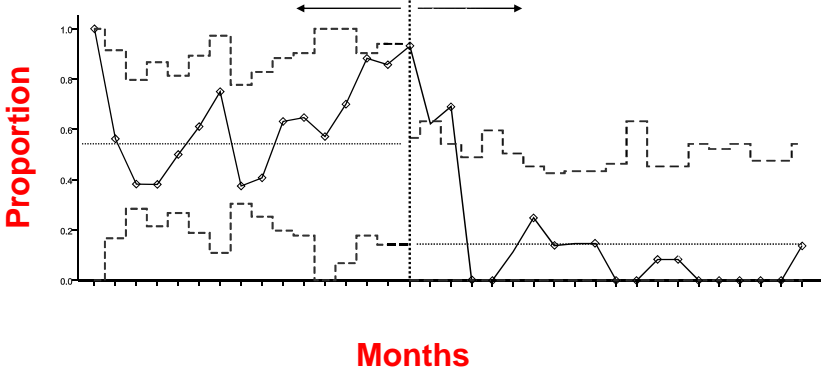

Outcomes (interview data)

- Patients feel part of the handover process and have input into their care.
- More accurate information is communicated.
- Better understanding of patients' conditions is gained.
- Patients are visually 'seen' sooner in the shift.
- Continuity of care is improved.
- Patient can prompt recall of important events and issues.
- Improves communication among staff at change of shift.
- More opportunities for teaching and modelling behaviours.
- Can be less time-consuming.





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P-Chart: Harm to Total Med Errors (3 wards combined)



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Implementation Issues

- Move to bedside handover must be driven by need to improve handover.
- Buy-in from staff is required.
- Change management process is crucial: ex. Lewin's 3 Step Model – Unfreezing, Moving, Refreezing.
- Avoid 'talking over' patients; limit the use of medical jargon.
- Explicit encouragement of patient involvement is needed.
- Numerous start times make implementation difficult.

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Standard Operating Protocol

- Focus is on what occurs at the bedside
- Other ward issues require handover

1. Preparation
2. Introduction
3. Information exchange
4. Patient involvement
5. Safety scan





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1. Preparation

Activities	Considerations
Patient allocation	Patient is comfortable to proceed with handover
Update handover sheet	Family are present with patient's consent
Inform patients	Privacy is secured
Request visitors other than family to leave	





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2. Introduction

Activities	Convene Participants
Outgoing staff greet patient	Outgoing team leader
Outgoing staff introduces oncoming staff to patient	Incoming staff
	Patient and family
	Shift co-ordinator





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3. Information Exchange

Activities	Considerations
Clinical condition	Acronyms to prompt information sharing
Tests and procedures	Changes in the patient's condition
ADL assistance	Changes in patient management
Discharge planning	Staff unfamiliar with patient
Queries from oncoming staff	





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4. Patient Involvement

Activities	Considerations
Ask patients if they have questions or comments	Patient confidentiality
Invite patient to confirm or clarify information	Sensitive information is shared in a private location
	Sensitive information may be recorded on the handover sheet





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5. Safety Scan

Activities	Activities
Call bell within reach	Tubes and lines checked
Equipment functioning	Medication chart reviewed
Access to mobility aids	Bedside chart review
Any final questions?	

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Conclusion

1. Bedside handover can improve content accuracy, and provides staff with learning opportunities.
2. Including patients in the handover acts as another safety mechanism in addition to the 'safety scan'.
3. Bedside handover can be successfully implemented if a structured approach to change is adopted.
4. Two drivers are needed for a change to bedside handover; top-down and bottom-up; One without the other increases the difficulty of successful adoption.

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