Implementing Nursing Bedside Handover

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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.
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
Data Analysis

- Descriptive statistics (SPSS)
- Thematic content analysis

Ethics Approval

- Two universities and two hospitals approved this study
- Consent was obtained from all participants
Results

- 532 bedside handovers were observed
- Average length of handover 1 minute 16 seconds (±45 sec)
- 34 in-depth interviews were conducted (15 RNs, 7 CNs, 7 ENs, 5 NUM/Educators); about half were full time.
### Observations

<table>
<thead>
<tr>
<th>Type of Ward</th>
<th>Hospital A Frequency (%)</th>
<th>Hospital B Frequency (%)</th>
<th>Total Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>186 (71%)</td>
<td>103 (38%)</td>
<td>289 (54%)</td>
</tr>
<tr>
<td>Surgical</td>
<td>N/A</td>
<td>93 (35%)</td>
<td>93 (17%)</td>
</tr>
<tr>
<td>Combined</td>
<td>N/A</td>
<td>73 (27%)</td>
<td>73 (14%)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>77 (29%)</td>
<td>N/A</td>
<td>77 (14%)</td>
</tr>
<tr>
<td>Report Content (SBAR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situation</td>
<td>171 (65%)</td>
<td>Not used</td>
<td>N/A</td>
</tr>
<tr>
<td>Background</td>
<td>148 (56%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td>118 (45%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations</td>
<td>156 (59%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active patient involve</td>
<td>85 (32%)</td>
<td>154 (57%)</td>
<td>239 (45%)</td>
</tr>
</tbody>
</table>
Overview of Results

**Structures**
1. Staff
2. Patients
3. Handover sheet
4. Bedside chart

**Processes**
1. Prior to handover
2. During handover
   - Content
   - Safety scan
   - Confidentiality
3. After handover

**Outcomes**
1. Staff
2. Patients
## Structures

| Staff                                      | 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                                  | 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)  

Processes – Prior to Handover

- 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.
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.
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.
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.
**Implementation Issues**

- How to handle patient confidentiality?
- How to handle variable start times?
- How to ensure shift co-ordinator receives handover information?
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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