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Nurse-to-Nurse Bedside Handoff: Improving Communication and Patient Safety

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PICOT Statement

Population - Nurse-to-Nurse

Intervention - Implementation of standardized bedside report and handoff tool

Comparison - No use of standardized bedside report and handoff tool

Outcome - Improved communication and patient safety

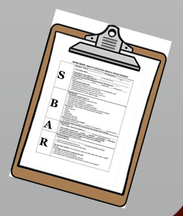
Time - During change-of-shift and patient handoffs

Abstract

Effective communication and patient safety are very crucial aspects of nursing care. Bedside nurse-to-nurse change-of-shift reports as well as a standardized handover tool are effective means of increasing shared understanding while improving the quality of care and the patients safety. Bedside reporting with a handover tool such as the I-PASS, SBAR, or SOAP note help to eliminate errors that occur when handovers are without structure. Bedside reporting is also a means of including the patient and their family in the care they are receiving, and thus increasing the quality of the patient centered care. Although there is a great deal of research done that proves the validity and effectiveness of nurse-to-nurse bedside reports and handover tools, there is a lack of implementation by hospitals. In this research, I cover the purpose and goal behind bedside reporting with a standardized handover tool, the problems that exist when no standard handover method is used, as well as interventions and improvements that can be implemented to bring about better outcomes in patent safety and effective communication.

Analyzing the Problem

- Standardized tool (I-Pass, SBAR, SOAP) and bedside report not being utilized across all hospital staff = discrepancies in communication
- Miscommunication and/or missing information creating errors
- Patients not active members of their own care
- Medication errors
- Patient harm risk is increased
- Nurse/ patient relationship influenced
- Need for in facility education and training on BSR and Handover tools.



Purpose

- The goal of Bedside Reporting (BSR) with a handover tool (I-PASS, SBAR, SOAP) is to improve patient safety and include the patient in their treatment plan. This provides the patient with a better understanding of their health care and creates a shared understanding.
- BSR and handoff systems help achieve the standards of patient care created by The Joint Commission found in the 2015 National Patient Safety Goals.
- Agency for Healthcare Research and Quality describes BSR as, “an opportunity to make sure there is effective communication between patients and families and nursing staff.”
- Nurses are better informed about the patient as both nurses are working together at the bedside. This ensures greater accountability and reduces the risk of miscommunication.
- BSR and a standardized handover tool also aids in time management and prioritizing as the oncoming nurse can identify patient needs during the report.
- Other institutions that have adopted BSR in a standardized format have seen the following:
  - Patient satisfaction scores reflect a more positive experience
  - Decrease in medication errors
  - Decrease in overtime related to the efficiency of the standardized format of reporting
  - Decrease in patient falls
  - Increase in overall safety

Interventions and Improvements

The AHRQ has an evidence-based guide to help hospitals work with patients and families to improve quality and safety.

- Critical Elements of BSR
  1. Introduce the nursing staff, patient, and family to one another.
  2. Invite the pt. and (with the patient’s permission) family to participate. The patient determines who is family and who can participate in BSR.
  3. Open the electronic health record at the bedside.
  4. Conduct a verbal report using the SBAR (or I-PASS) format in vocabulary the patients and family can understand.
  5. Conduct a focused assessment of the patient and a room safety assessment.
  6. Review tasks to be done.
  7. Identify patient’s and family’s needs and concerns.

- Education and Training: Initial entry training on handoff system to completely familiarize all healthcare staff on the use of I-PASS, SBAR, or SOAP format (facility chosen format). This ensures that new nurses have the understanding and confidence in the system to find their own mistakes, but also the mistakes that could be missed by their co-workers.

Interventions and Improvements (cont.)

- Not only lectures, but practical exercises: Allows for hands-on experience with the system to ensure their understanding of how to practically use the standardized handover system in the hospital.
- Annual training on I-PASS: To ensure that staff is maintaining the standard that they were initially taught.
- Surveys (Patient and Staff): To evaluate use and effectiveness of hospital standardized handover tool .

Outcomes

- Economic Impact - “decrease in overtime hours or related cost” (Review Bedside Shift-to-Shift Handoffs: A Systematic Review of the Literature, Mardis, 2016)
- Reduction of medical errors including medication and patient rights (New England Journal of Medicine, 2014)
- Increased Patient Safety and Quality of Care
- Increased Patient Satisfaction
- Shared understanding and effective communication facilitated for Nurse-to-Nurse and Nurse-to-patient and families communications

Gaps in the Literature

- Lack of implementation in facilities / need for leadership and training.
- Not enough research done to determine the most effective format tool for each department or hospital setting (I-PASS, SBAR, SOAP).
- Studies done on one unit or ward, not hospital wide.
- Studies needed to determine how BSR with a handover tool can be transferred from unit to unit (example: ER to Med surge) in a clear standardized format.
- Results are dependent greatly on patient and nurse staff participation and qualitative reports.

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