

Moving Patient Handoff Report to the Bedside

AMH

Lisa Henry, RN, Stefanie-Jo Wright ,RN, Melissa Morant RN, Ayanna Burnett RN

THE PROBLEM

Despite the evidence linking bedside handoff reports to improved quality and patient safety, nurses at the Andrews Memorial Hospital continued to do a general handover away from the patient's bedside. Additionally, the report was not standardized and often missed critical information, such as patients' lab results. Patients on Unit 300 continued to experience medication errors and falls.

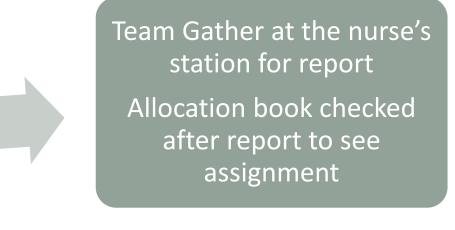
AIM

- 1. Improve the quality of patient handoff using a **Situation**, **Background**, **Assessment**, **Recommendation** (SBAR) tool.
- 2. To improve the quality of care on the unit as evidenced by decreased patient falls and decreased medication errors

FLOW MAP OF PRESENT STATE

Change of shift

Off going team leaves, and the charge nurse stays to give report to the oncoming team





Report is given on all 15 patients then, then the nurse goes to see each patient

FLOW MAP OF FUTURE STATE

Before Change of shift: White board updated with patient allocation

Nurses Identify the person to whom they will give or get report from and go to the patient's bedside with the patient's docket

Off going nurse introduces oncoming nurse to the patient.
Report given in SBAR format. Patient given opportunity to ask questions, other concerns addressed at that time as well

PLAN DO ACT STUDY CYCLE

PLAN

Test moving the handoff report to the bedside. We hope to see decreased patient falls and decreased medication errors. Search the evidence, find a standardized communication tool, educate team and execute plan on the medical ward

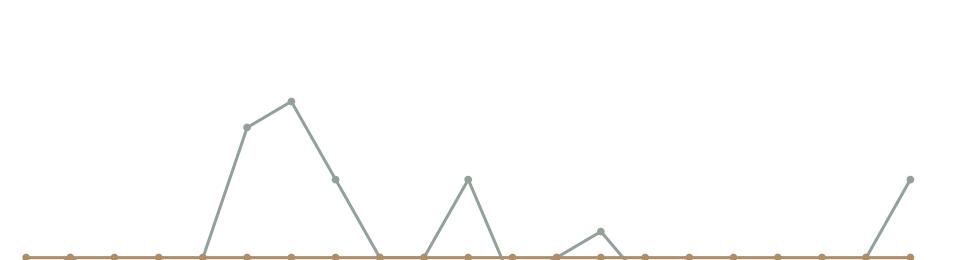
In the future ensure principles of change of change management is utilized to reduce push back when rolling out in other areas. Continue to encourage team's consistent use of the SBAR to minimize missed information. Implement daily Huddle after report to discuss patient safety issues can be

help to improve safety.

Staff continued to voice reservations about not receiving report on all ward patients. There was bundling at the nurse's station as nurses tried to figure out their assignments. Some charge nurses on evening shift continued to conduct general hand over. Some RN's voiced satisfaction with the process, as they were able to finish report and leave the unit in a timely manner

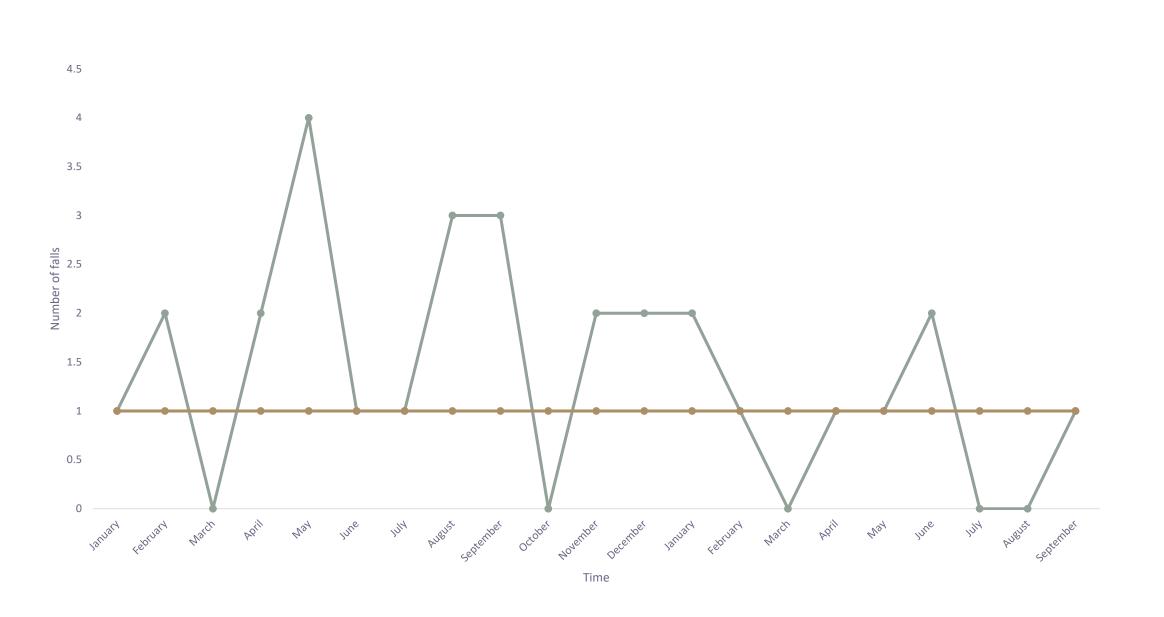
The Process change was successful. Patient falls decreased, medication errors decreased and many near misses were caught before it reached the patient. Challenges remain with the quality of the information that is exchanged, and this will require continued monitoring

DATA



Jan2021- Sept 2022

Patient Falls



RESULTS

- The Test of change was rolled out on October 16, 2021. After plotting the data for falls and medication errors on the run chart no significant patterns were revealed over the 1-year period. However, the data reveals that prior to October 2021 there were 30 medication errors and 21 falls on the unit. This year and we have had less than half the amount of medication errors (14) and less than half the number of falls as well (8).
- Although the run charts did not reveal significant patterns, the raw data shows that patient safety is moving in the right direction. There are other factors that have impacted our nursing practice, such as increased turn over of experienced nursing staff, the covid-19 pandemic significantly impacted our nurse-to-patient ratio from time to time. Those factors can also contribute to inconsistent nursing practice and errors.

SUMMARY

Change must be managed properly to sustain improvements.
Bedside shift report enables accurate and timely
communication between nurses and allows the patient and
family engagement .Bedside shift report is essential in the
delivery of safe high-quality care. The practice is patient
centered and supports improved quality of care.

FUTURE STEPS/ WHAT'S NEXT?

- We have since implemented the process on two other nursing units. We are working to implement it on the maternity unit soon.
- We want to ensure our next project is guided by change management theory. As we work to improve quality work must also be done to improve communication and teamwork related to bedside hand off report.