Standard Operating Protocol for Implementing Bedside Handover in Nursing

Prepared for

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Professor Wendy Chaboyer
Professor Anne McMurray
Professor Marianne Wallis
on behalf of
Griffith University
and
Murdoch University

2008

Griffith UNIVERSITY

Murdoch UNIVERSITY

Published by the Research Centre for Clinical and Community Practice Innovation (RCCCPI)
Griffith University
Gold Coast campus, Qld, 4222

Suggested Citation:
Chaboyer, W., McMurray, A., Wallis, M. & Chang, H.Y. (2008) Standard Operating Protocol for Implementing Bedside Handover in Nursing, Griffith University, Australia

About the Authors

Professor Wendy Chaboyer RN BSc(Nu) MN PhD
Director, Research Centre for Clinical and Community Practice Innovation, Griffith University Queensland

Professor Anne McMurray AM RN PhD FRCNA
Peel Health Campus Chair in Nursing, Murdoch University, Western Australia

Professor Marianne Wallis RN BSc(Hons) PhD FRCNA
Chair, Clinical Nursing Research Griffith University and Gold Coast Health Service District, Queensland

Dr Hsiao-yun Annie Chang RN BN MN PhD
Research Fellow, Research Centre for Clinical and Community Practice Innovation, Griffith University Queensland

The primary contact person for this project is:

Professor Wendy Chaboyer
Research Centre for Clinical and Community Practice Innovation
Griffith University
Gold Coast campus, QLD 4222
Tel: 61 (0) 7 5552 8518
Email: W.Chaboyer@griffith.edu.au

Table of Contents **Page**

Clinical Handover in Nursing

Clinical handover is defined as the transfer of responsibility and accountability for patient care from one provider or team of providers to another (Australian Medical Association, 2006). It is a key initiative to improve patient safety (Australian Commission for Safety and Quality in Health Care ACSQHC, 2007; World Health Organization, 2007). A variety of handover techniques have been used by nurses, such as taped and verbal reports given in staff rooms. Recently, bedside nursing handover has emerged to improve the accuracy of handover communication (Lally, 1999; Philpin, 2006). It promotes a patient centered approach to care (Rutherford, Lee & Greiner, 2004), and with patient contribution, it can improve patient safety and increase both patient and nurse satisfaction. This document describes a Standard Operating Protocol (SOP) for bedside handover in nursing. Importantly, while patient information is handed over at the bedside, unit information such as sick leave and in-services, is handed over away from the bedside, generally before or after the bedside component of the handover.

This SOP for bedside nursing handover is based on our research conducted in six wards of two hospitals in Queensland and Western Australia in 2007-2008. We observed over 500 bedside handovers and interviewed over 30 nurses. Our research shows that when a change management process is used, bedside handover can be successfully implemented in a variety of clinical situations. What appears to be key is nurses' recognition that bedside handover facilitates more accurate information exchange, and provides nurses with the opportunity to work in partnerships with their patients. Also important is the recognition that bedside handover does not extend the time taken for handover, with about 1.5 minutes on average spent at each bedside. In fact, it actually saves oncoming nurses time because the handover is comprehensive, and prompted by visualising the patient, it assists in identifying care priorities. Oncoming nurses do not passively receive information; they are active participants, questioning outgoing staff and patients and leading the safety scan and medication review, thus promoting patient safety. Finally, the legitimate concerns related to patient

privacy and confidentiality can be easily managed. In fact, our medical colleagues have long shown that while concerns surrounding sharing patient information in multi-bed rooms should not be ignored, numerous strategies can be used to ensure sensitive patient information remains confidential. Our research has shown that sensible and sensitive approaches to sharing confidential patient information are easily undertaken. A short summary of this research is provided in Appendix A.

This SOP for bedside nursing handover is intended to act as a resource for its implementation. First, an overview of bedside handover is provided. Second, a detailed description of the steps in the process is given. Finally, some examples of the variations to this process are briefly outlined. We have provided direct quotes from our research in "sidebars", to show what nurses who participate in bedside handover think about it. We use the 'stars icon' to highlight tips and use a tick to indicate particular issues that should be considered. Finally, boxes are used to display examples. These various symbols and their meanings are displayed below.

Direct quote from the research

Tips

☑ Tick

Particular issue to be considered

Example

Prior to implementing bedside handover in nursing, it is important to consider why such a change will be beneficial, what barriers there may be to its adoption, and how a change management strategy should be developed. Further,

bedside handover focuses on sharing patient information but unit information will be shared away from the bedside.

Overview of Bedside Nursing Handover

Figure 1 provides a schematic overview of the bedside handover process. Each of the five steps is detailed in the following section.

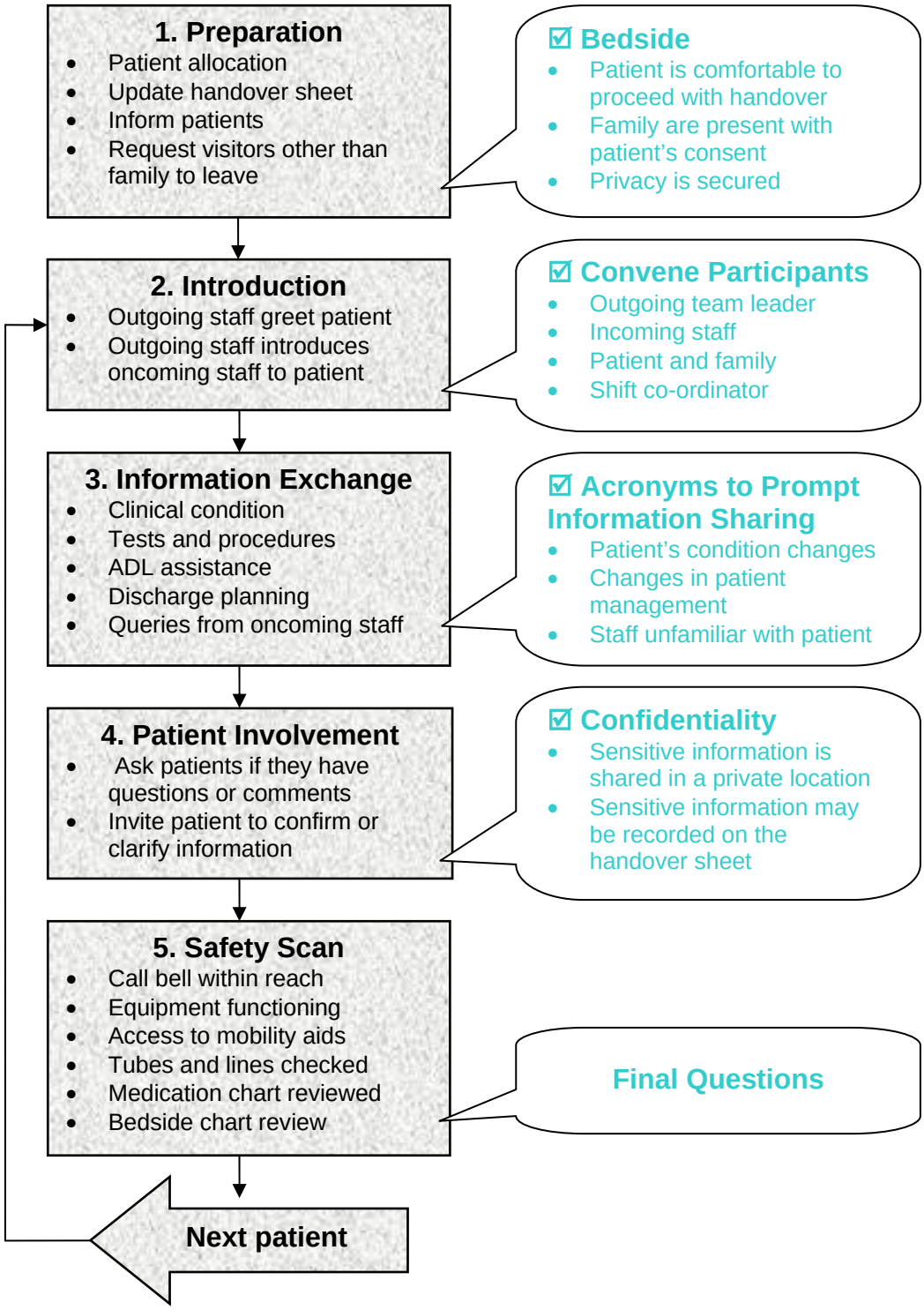

Figure 1: Schematic Overview of Bedside Handover

Detailed Description of Bedside Nursing Handover

Nursing handover is the primary method of sharing patient information between shifts and ensuring continuity of care from shift to shift. Nursing handover at the bedside should be an interactive process, providing opportunities for input and questions from oncoming and outgoing as well as for obtaining the patient's viewpoint. In particular, bedside handover ensures that patients remain at the centre of their care. In the research that underpins this SOP, team nursing was used with 2-3 teams of nursing staff per ward. Handover occurred between these smaller teams; not as a 'whole of ward' handover. Although the principal intention of handover relates to sharing patient information, other functions we found included opportunities for teaching, and building group cohesion. This section provides a detailed description of how to undertake bedside nursing handover, following the schematic overview of bedside handover (Figure 1). The headings in this section follow the five steps in this overview including:

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

"Bedside handover, I am 110% for it, it's the best thing ever"

1. PREPARATION

There are four aspects to the preparation for bedside handover:

1) Staff and patient allocation;
2) Updating the handover sheet;
3) Informing patients; and
4) Family and Other Visitors.

1.1 Staff and Patient Allocation

Bedside handover has been used successfully where team nursing is practised. A team nursing approach provides care for a specified group of patients by a designated team of nursing staff such as registered and enrolled nurses, and assistants all working together. There are no special considerations for staff and patient allocation when bedside handover is used. That is, the ward's standard practice should be followed.

"Handover at the bedside is good because the patients then see that you do know about them which gives them more confidence in your ability to look after them and also they can be involved."

1.2 Updating the Handover Sheet

A computer generated electronic handover sheet that contains information about **all** patients on the ward is a **key tool** that is required when bedside handover is implemented. The handover sheet allows nurses to gain an understanding of the patients on the ward that they do not receive bedside handover on. It is therefore crucial that this handover sheet is updated every shift. The information that is contained on this sheet may include: age, gender, admitting diagnosis, medical history, social history, changes in condition, pending tests and results, discharge planning, and sensitive information such as HIV status. Box 1 contains one example of a handover sheet. The handover sheet can be tailored to the needs of the particular ward.

Box 1: Example of an electronic handover sheet

Bed	Pt	Dr	Age	Dx	Admission Date	Notes
01	Annie Griffith	Smith	65Y	Cellulitis L Leg	16/06/2008	Hx: IHD,PVD, HTN, Lives alone. Multiple admissions for leg ulcers. Self- discharges on occasion; awaiting social work assessment; needs 1 assist to help mobilise.
04	Laoi Chapell	Jones	60Y	Uncontrolled A Fib	10/06/2008	Hx: COPD, CCF. lives alone, transferred from ICU 11/06 after cardioversion; VS stable; expected D/C 14/06

When team nursing is practiced, the team leader, not the shift co-ordinator should have ultimate responsibility to ensure the handover sheet is up to date and accurate.

"Giving 100% attention to H/O shows the patient that I care for them and that they're important."

It is helpful to have components of the health record, such as the observation record, care plan, medication record, fluid balance sheet and risk assessment forms such as falls or pressure ulcers at the patient's bedside. This bedside chart may be placed on a clip board hanging from the foot of the patient's bed and should be checked for completeness prior to handover.

1.3 Informing Patients

Toward handover time, team members should inform patients that the handover will begin shortly. This signals to patients that the staff caring for them will soon change and allows patients to prepare for the handover, including what contribution they may want to make.

"Patients are often a really valuable source of information"

1.4 Family and Other Visitors

With the patient's permission, family members are allowed to stay at the patient's bedside during the handover. Other visitors should be asked to leave the room during the handover.

☑ Bedside

- *Patients are comfortable prior to beginning the handover.*
- *Families are present with the consent of the patient.*
- *Visitors are asked to leave the bedside.*

2. INTRODUCTION

The team leader of the outgoing team should lead the handover, with the remaining outgoing team members available to answer call bells and provide other care. Because the outgoing team leader has already built a rapport with the patient, they should introduce the oncoming team members to the patient and family. The outgoing team leader should ensure a personable approach is maintained. The shift co-ordinator's attendance at bedside handovers varies according to whether they have a patient load. If they are allocated a patient load, they attend their team's handover. Then, either before or after this, they receive handover from either the shift coordinator of the outgoing staff or the other team leaders of the oncoming teams. At times a shift coordinator to shift coordinator handover will occur away from patients' bedsides, and will include managerial and other unit related information.

☑ Convene Participants for Handover

- *The team leader of the outgoing team leads the handover, with other outgoing team members available to provide care.*
- *All of the oncoming team members attend the handover.*
- *The shift co-ordinator's attendance at bedside handovers varies according to whether they have a patient load.*
- *Staff commencing outside of the bedside handover periods use the handover sheet as a guide and provide care under the direction of the team leader.*

Patients may be given the option for the handover to occur away from the bedside, especially if they are located in a room with several beds per room.

"If they're [patients] uncomfortable, obviously you don't have to do theirs [the handover] at the bedside, you can do theirs outside the room or in the nurses station."

3. INFORMATION EXCHANGE

Accurate and detailed handovers are crucial to ensure oncoming staff can provide safe care. In general, the information handed over at the bedside does not differ to what would be exchanged when other forms of handover are used, however staff should be cognisant of the language they use, limiting medical jargon when possible. A real safety benefit of bedside handover is the fact that visualising the patient may prompt nurses to recall important information that should be handed over and it may also trigger oncoming staff to ask additional questions. Further, patients have the opportunity to clarify content. Outgoing staff should strive to communicate information accurately, succinctly and professionally. Box 2 contains the information that is generally shared during the handover.

Box 2: Example of information shared during bedside handover

1. Date and reason for admission	5. Nursing care plan and patient response
2. Relevant medical history including new referrals	6. Safety concerns
3. Investigations	7. Discharge planning
4. Treatments and patient response	8. Recommendations for future care

"You can get a lot more observation and draw a lot more information when you actually look and see for yourself."

☑ Acronyms to Prompt Information Sharing

A number of acronyms have been developed to provide structure to the handover and help remind nurses about the information they should share during handover. Using these acronyms may be particularly important when:

- *The patient's condition changes*
- *Changes in the proposed nursing or medical management of the patient*
- *Staff are unfamiliar with the patient*

Two acronyms are displayed in Box 3.

Box 3: Example of two acronyms to prompt information sharing during bedside handover

SBAR	ISOBAR
S: Situation – chief complaint, current status B: Background – previous history A: Assessment –result of assessment, vital signs and symptoms R: Recommendation – suggested and anticipated changes, critical monitoring	I: Identify the patient and staff S: Situation and status O: Observations, MET calls etc. B: Background A: Accountability R: Risk management

Gossip and derogatory comments have no place during bedside handover. Language should be maintained at a professional and reasonable level.

"I think the information that we're handing over is often a lot more professional, and you're getting a more comprehensive picture of what's happening."

4. PATIENT INVOLVEMENT

In a patient-centred approach to care, it is important to involve the patient in handover. Patients should be provided with opportunities to seek clarification, ask questions and confirm information. Specifically, the outgoing nurse who is giving the handover should invite patients to comment or ask questions during the handover. Family members should be invited to participate in the handover with the patient's consent. Patient groups that may not participate in handover include those who are:

- Asleep;
- Confused;
- Comatose;
- In isolation;
- Have difficulty communicating in English
- Other conditions that precludes participation;

"If you speak to them [patients] during the process they feel like they're involved…they know straight away who's looking after them, they can put a name to the faces."

☑ Confidentiality

Patient confidentiality can be an issue if not adequately addressed, but it has also been overcome by our medical colleagues. A number of strategies can be used to ensure that patient confidentiality is maintained.

For example:

- *Sensitive information can be shared away from the bedside*
- *Staff should lower their voices when sharing sensitive information*
- *Sensitive information may be recorded on the handover sheet*

Sensitive information may include:

- Blood tests of a diagnostic nature (eg. HIV positive);
- Communicable disease information (eg. Hepatitis);
- Psychiatric issues (eg. suicidal, ethanol abuse)
- "Not for resuscitation" orders,
- Some family issues (eg. conflicts, domestic violence);
- Anything else patients identify they wish to be held in confidence.

"Bedside handover lets patients know that they're actually valued and it also gives the family an opportunity to participate as well."

5. SAFETY SCAN

During the handover, undertaking a safety scan promotes patient safety and appears to be one significant benefit of bedside handover. This scan includes the environment, the patient and the bedside chart.

5.1 Environmental Safety Scan

During the bedside handover, oncoming staff should undertake a safety check of the patient's environment and equipment.

Key items to consider are:

- The patient's call bell is in reach;
- Suction, oxygen or other equipment are in working order and easily accessible;
- Dressings, drains, intravenous fluids and infusion pumps are secure and correct;
- The general tidiness of the area is conducive to safe mobility and ease of access and
- Any other checks that may be specific for that patient (eg. use of bed rails, height of the bed etc)

5.2 Patient Review

A physical review of the patient may include observing catheters, drains and dressings. This review will allow outgoing staff to better explain problems or issues.

"You generally find out a clearer picture once you actually go and talk to the patient yourself."

5.3 Bedside Chart Review

Near the end of the bedside handover, the oncoming team leader should review the bedside chart to identify additional safety concerns such as medications not signed for and changes in vital signs. The following sheets should be checked: care plan, observations (including vital signs),

medication sheet, fluid balance sheet, any risk assessments such as falls or pressure ulcers.

A bedside chart review provides a check of the care and medications that have been given, allowing outgoing and oncoming staff to discuss discrepancies or other issues.

"Any mistakes are picked up straight away and they're not carried on for the next couple of shifts."

☑ Final Questions

- *The oncoming staff should ask questions if further clarification is needed prior to leaving the patient's bedside.*
- *Upon the completion of handover, outgoing staff should ensure that all confidential information has been passed on to the next shift.*

"If you engage the patients properly they give you good feedback from it, so therefore you feel better about everything."

A case example of bedside handover is provided in Box 4.

Box 4: Example of a Medical Patient's Handover

Preparation	RN Annie is a team leader. She reads the patient's medical record before handover ensuring she is up to date with the medical decisions recorded in the doctors' notes. She checks the bedside chart to ensure everything in the handover is accurate. Towards handover time, RN Annie gets the team members together to update the handover sheet. Annie tells the patient that handover will occur shortly, ascertains whether the patient wishes family to be present during the handover and ask non-family members to wait outside for a short while. All oncoming staff members are given a handover sheet.
Introduction	"Mr. Smith, good afternoon, This is Sylvia, a RN, Cindy an EN and Susan, a nursing assistant. They will be taking care of you in the evening shift."
Information exchange S: Situation B: Background	RN Annie keeps her voice low but ensures that Mr. Smith and the oncoming staff can hear her. S: Mr. Smith came to the ED complaining of chest pain and shortness of breath. He was placed on O_2 via nasal cannuala at 2l/min. He is on an antihypertensive, aspirin and a beta blocker (medication record shown to Nurse Sylvia). B: Mr. Smith has a history of chest pain over the past two days, which radiated down

A: Assessment R: Recommendations	his left arm. He has prn anginine at home. Over the past 6 months he has had several bouts of chest pain, and has been followed by his GP. Today, prior to being admitted, he developed chest pain but is currently pain free. A: This afternoon, his BP=130/86, Temp=38.0 and Heart Rate=76. He is currently pain free. R: Doctor Jones has arranged a cardiac echo for him. He has had an ECG today with no significant changes. Blood tests all attended and are waiting on results. RN Sylvia then asks about any treatment for his raised temperature and also questions about mobility. Nurse Annie responses: "Dr. Jones is aware and has asked to be notified if it goes above 38.5." Mr. Smith can mobilise with assistance but only toilet and shower privileges.
Patient involvement	Nurse Annie asks "Mr. Smith, have you been to cardiac echo?" Mr. Smith says "yes". Nurse Annie then asks, "Did the doctor say anything to you?" Mr. Smith says, "She said, I may need a cardiac catheter" Nurse Sylvia then asks "Do you have any questions Mr. Smith?" Mr. Smith states "Can you find out if I need the cardiac test?"
Safety scan	EN Cindy undertakes a safety check of the equipment, including checking that the call bell is within reach, the suction and oxygen equipment are functioning. RN Sylvia and RN Annie review the bedside chart, checking the following: care plan, observation chart, medication chart, fluid balance chart, and the pressure ulcer assessment. RN Sylvia asks "Has Mr. Smith needed any GTN recently?" RN Annie said "Oh, I forgot, Mr. Smith had chest pain around 9:30 am and took one GTN sublingually. This was relieved within 5 minutes. Yes. I will sign for the med now."
Handover completed	Nurse Annie said "Mr. Smith, we have finished the handover, do you want to add anything before we leave?" Mr Smith said, "No, I'll wait to hear about that other heart test."
Confidentiality	After finishing the handover in the 4 bed room, all staff went out the room in the corridor, nurse Annie said " I have to hand over some sensitive information related to Mr Smith; he has hepatitis C, so make sure you adhere to universal precautions when undertaking his care."

Variations in Handover Information

A number of variations may be adopted when undertaking bedside handover. While it is not possible to list all of these variations, some options include:

- Ward variation – The specific content of the handover may differ among various types of wards such as oncology wards and rehabilitation units. Information on patient transfers may differ on medical and surgical wards, particularly where patients are expected from theatre or post-anaesthetic units. There needs to be a consistent way to convey unit related information such as sick leave and in services, to ensure all

staff are informed about this information. Adding a section to the handover sheet is one means of conveying information in a written format. A second strategy is for all oncoming staff to receive a brief unit update as a group at the start of their shift, prior to beginning bedside handover.

- Patient variation – Some patients may not want to be involved in bedside handover. Their wishes should be respected and an alternative approach to the handover should be undertaken. For example, the handover could occur in the hallway, just outside the patients' room.
- Staff variation - Inexperienced or less familiar staff, such as casual or agency staff, may require more in-depth explanations in order for them to comprehend the handover information. When all receiving staff are familiar with the patient's history, diagnosis and current condition, some aspects may be excluded during handover focusing instead on recent and anticipated changes. The extent to which information is excluded should always be considered in relation to the potential risk this exclusion may have. In other areas, redundancy of key information (i.e. repeating of information), has been shown to improve safety.
- Shift variation – Night shift handover (or other handovers when the patient is asleep) may occur in the corridors, with a quick 'walk around' undertaken during the handover. If a staff member comes on duty at a different time, they may receive handover from the team leader not at the bedside, however, they would then attend the next bedside handover.

Summary

Effective communication amongst health professionals is the key to ensuring quality care in clinical practice. This SOP for implementing bedside nursing handover provides a toolkit for those interested in adopting bedside handover. Grounded in a patient-centred approach to nursing care, bedside handover is one nursing activity to promote continuity of care. The research upon which

these SOPs are based uncovered many benefits of bedside handover for both staff and patients. Importantly, it promotes patient participation in their care and helps nurses gain a better understanding of their patients and priorities for their work. The handover process documented here has considered preparation, introduction, information exchange, patient involvement, safety scan and examples of variations that may influence the handover. This toolkit is designed to provide guidance to nurses wanting to implement bedside handover.

"Bedside handover streamlines handover and makes the patients more involved in the handover."

"Makes patients feel they're actually part of the process…that they're actually valued, and gives the family an opportunity to participate."

References

Australian Commission on Safety and Quality in Healthcare (2007). *The Commission's Nine Priority Programs*. Canberra: Australian Health Ministers' Conference on 24 July 2007. http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/programs-lp

Australian Medical Association (2006). *Safe handover: Safe patients; guidelines on clinical handover for clinicians and managers*. http://www.ama.com.au/web.nsf/doc/WEEN-6XFDKN/pdf (accessed June 2007).

Lally, S. (1999). An investigation into the functions of nurses' communication at the inter-shift handover. *Journal of Nursing Management*, 7, 29-36.

Rutherford, P., Lee, B. & Greiner, A. (2004). *Transforming care at the bedside*. Cambridge, Ma: Institute for Healthcare Innovations.

Philpin, S. (2006). "Handing Over": transmission of information between nurses in an intensive therapy unit. *Nursing in Critical Care*, 11(2), 86-93.

World Health Organization (2007). *Communication during patient hand-overs. Patient Safety Solutions*, 1(3). Accessed from http//www.who.int/patientsafety (26 May, 2008).

Appendix A

Summary of the Bedside Handover Research

W. Chaboyer, A., McMurray, M. Wallis

Introduction: The aim of this study was to describe the structures, processes and outcomes of nursing bedside handover in medical and surgical wards in two hospitals.

Methods: A case study method with nested 'cases' on six wards was used. Data collection included observations for five days per ward and in-depth interviews with nursing staff. Thematic content analysis and descriptive statistics were used to analyse the data to identify structures, processes and outcomes of bedside handover.

Results: A total of 532 bedside handovers were observed and 34 nurses interviewed. Structural components of the handover are described in Table 1. In terms of processes, both sites used a computer generated handover sheet. At one site, SBAR was used to convey information and safety and medication checks were included. Confidential information was shared away from patients and visitors, often in hallways. Bedside handover improved the quality of information, provided opportunities for teaching and saved time. It allows senior nurses to model behaviours that promote patient safety and facilitates the development of critical decision making skills among nursing staff.

Table 1: Overview of Bedside Handover Structures

Structure	Description
Staff	• Team nursing used to deliver care. • Handover generally attended by team leader of the outgoing staff and all members of the receiving staff. • Shift co-ordinator's attendance at bedside handovers varies according to whether they have a patient load. • Shift co-ordinator either attends one team handover and receives short report from other team leaders or received a shift co-ordinator to shift co-ordinator report away from the bedside.
Patients	• Patients who generally do not participate in the handover include those that are: asleep, hard of hearing, confused, comatose, have difficulty communicating in English and/or in isolation.
Handover sheet	• Computer generated sheet, updated regularly, contains information about all patients on the ward. • Individual patient information includes: age, gender, admitting diagnosis and medical history, social history, discharge planning, changes in clinical condition, and sensitive or confidential information such as HIV status. • Oncoming staff writes their plans for patient care for the shift on this sheet, noting required care, observations, tests etc.
Bedside chart	• Components of the health record, consisting of the observation record, medication record, fluid balance sheet and risk assessment forms (falls, pressure ulcers) are at the bedside for use during the handover.

Conclusion: Implementing bedside handover is one strategy to transform nursing care at the bedside. Clinical leadership and a focus on patient centred care are two key elements for successful implementation of bedside handover.