Better Bedside Handover

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Introduction

- Clinical handover is a pivotal, high-risk communicative event in hospitals[1].
- Ineffective communication is a major contributing factor to critical incidents and patient harm[2].
- Over 40 million handovers are performed nationally each year, each representing an opportunity for miscommunication and risk to patient safety[3].
- Bedside handover was mandated in 2008 in Australia[4], however implementation was not accompanied with the recommended training.
- Patient involvement in handover is a critical factor in preventing errors and patient harm[5].
- Researchers from the Institute for Communication in Health Care (ICH) at the Australian National University (ANU) collaborated with St Vincent's Hospital Sydney (SVHS) to undertake a bedside handover study within a medical Neurology, Stroke and Vascular unit.

Methods

- Thirty-nine audio & video recordings of actual patient handovers were collected.
- Interviews were conducted with clinicians and patients.
- Three group handovers and 3 multidisciplinary meetings were observed.
- Interviews and recorded handovers were transcribed and results linguistically analysed.
- Findings from the data analyses were used to create a face-to-face training program for nursing staff.
- A two hour training intervention was delivered to nursing staff incorporating de-identified verbatim transcripts and re-enacted video of nursing handovers.
- Protocols designed to improve the interactional (CARE[2] - Connect, Ask, Respond, Empathise) and informational (ISBAR[6] - Introduction, Situation, Background, Assessment, Recommendations) elements of handover were included in the training.
- The nursing handover sheet was redesigned to follow the ISBAR format.
- Patient experience survey data and bedside handover observational audit data was analysed post training.
- Ward hospital acquired complication data was analysed post training (Dec 2018 to Apr 2019) and compared to an average of the same months over the preceding three years.

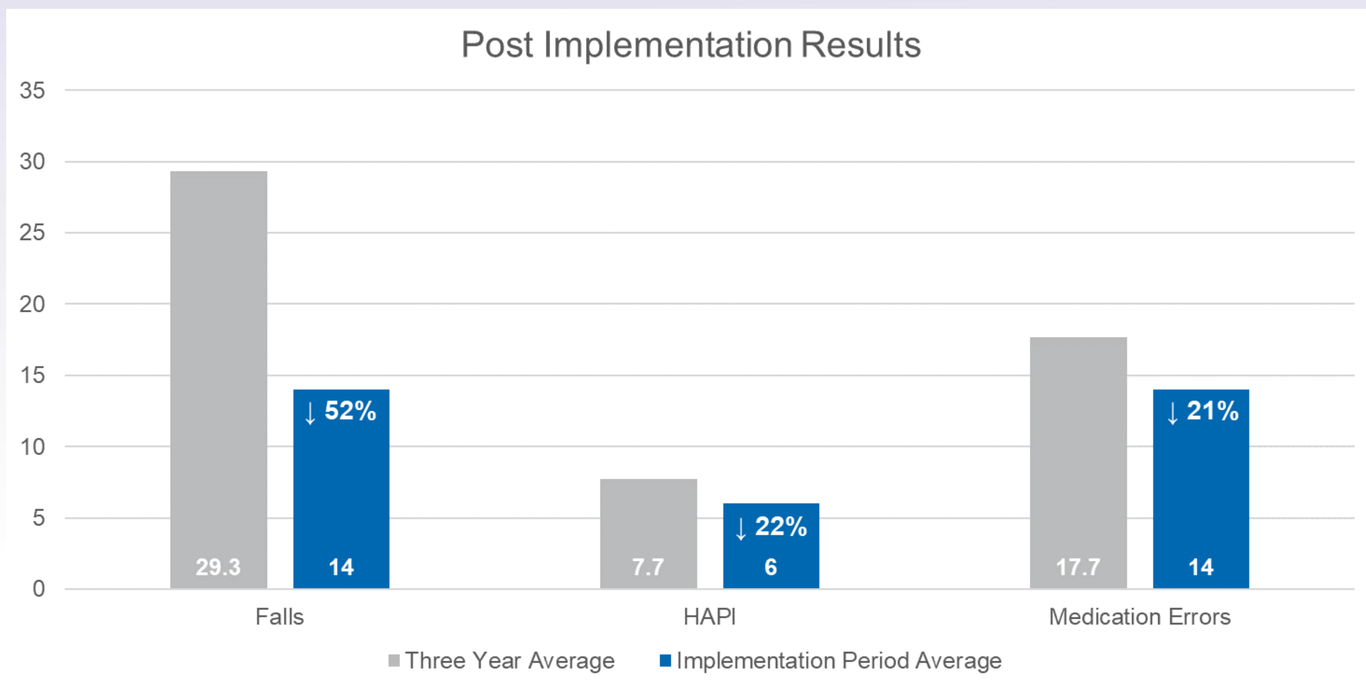
Results

Pre-training

- Bedside handover was given in corridors, with a lack of interaction with both patients and incoming nurses.
- Information shared was often duplicated and misunderstood, with poor opportunity for clarification.

Post-training

- **90%** of frontline nursing staff (n=50) received the face-to-face training.
- Bedside handover is now given at the bedside as intended and patients and families are included in the communication.
- Traditional shift to shift group handover (30mins) was replaced with a 'ward forecast' (10mins), a focused meeting for communication of patients at risk of harm (e.g. risk of falls, deterioration, pressure injury) to all staff on shift.



This showed:

- **52%** reduction in inpatient falls
- **22%** reduction in the number of hospital acquired pressure injuries (HAPI)
- **21%** reduction in the number of reported medication errors.
- **94%** (n=92) of patients reported nurses displayed courtesy and respect in the biannual Press Ganey survey.
- **81%** (n=92) of patients reported strongly positive satisfaction with nurses' communication.

From Left: *Anna Thornton – Network Director of Nursing, Professor Diana Slade – Australian National University, Joanne Taylor – Nurse Manager Clinical Practice and Innovation, Sam Ohoshi – Nurse Unit Manager, Ethan Watters – Clinical Nurse Educator*

Sustainability

Observational audits revealed that:

- **93%** (n=22) of handovers adhered to the recommended ISBAR protocol.
- **95%** (n=22) of handovers adhered to the CARE protocol.
- **95%** (n=22) of staff involved patient and family members in bedside handover.

Discussion and Conclusions

- Patient participation in clinical handover reduces errors and patient harm.
- The training has significantly improved nursing handover practices.
- Linguistic analysis, use of handover protocols (CARE[2] and ISBAR[6]), the creation of real handover transcripts and video re-enactments were effective training tools.
- This innovative intervention has reduced healthcare associated complications resulting from communication failures, supports positive patient experiences and has promoted a stronger safety culture in the unit.

Acknowledgements

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References

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