IMPLEMENTATION OF A REHABILITATIVE BEDSIDE CLINICAL HANDOVER IN AN INPATIENT REHABILITATION SETTING

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Background

The goal of rehabilitation is to optimise patient functioning (or self care) & preparing the patient & family for discharge home. To ensure a stream lined patient rehabilitation journey, communication of the patient and family needs, goals & where they are up to in the rehabilitation program is important. Clinical handover is a tool for facilitating this handover between nursing shifts.

Method

The project team was comprised of 7 staff members from the ward who identified the project aim, objectives and Implementation plan. Patient and staff surveys and audits tools were developed by the project team. In-services were provided to all staff to introduce the project and to provide feedback about the pre-implementation results. At this time, staff requested that the improved bedside clinical handover be implemented only between morning and afternoon shifts as patients are asleep during this time.

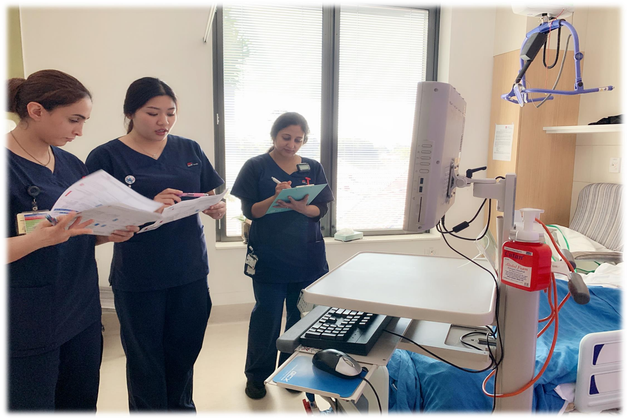
Pre- and post- implementation staff and patient surveys were attended to identify current practice, patient participation & satisfaction, and to determine changes in staff practice.

A cue card was designed by the project team members to assist staff provide a more rehabilitative, comprehensive and consistent clinical handover. An ISBARS clinical hand over post-audit was conducted to determine effective use of the cue cards.

Aims

The aim of this project was to develop a clinical hand over tool that would identify patient and family needs, goals and level of patient and family participation, which will add a rehabilitative focus to bedside clinical handover.

ISBAR
Introduction (greet/introduce)
Situation(immediate clinical situation)
A-ADL's(full/mod/min assist with showers & dressing)
B-Behaviour(Alert/orientated/confused)
C-Continence(pads/toileting regime)
D-Dressings &Pressure Injury(waterlow/skin inspection)
E-Eating&Drinking(red/blue mat/food chart/assistance)
F-Falls risk(mobility/sensor mats/bracelet/floorbed)
G-Goals(nursing goals as on care board)
H-Home(EDD/discharge destination/lives alone/services)
Background(relevant clinical history)
Assessment(vitals/stable/CERS/Meds./other charts/NFR)
Recommendation(further assessments/MSU/XRAY/apts.)
Safety scan(Intentional Rounding)



Results

Comparisons of the survey results for patients indicate an increase of patient participation in bedside clinical handover. In the pre- survey, 50% of the patients reported that they do not participate in bedside clinical hand over in comparison to 30% in the post survey.

Comparison of the pre and post survey results for staff identified that 51% of staff included the patient in clinical handover for the first survey and this increased to 70% in the post-implementation survey. 99% of staff also reported a positive change (‘always’ or ‘sometimes’) in clinical hand over.

Results for the post ISBARS clinical hand over audit indicated a positive result of 50 to 90% in the majority areas. However, only 20% of staff documented in the areas for Goals and Discharge,

Conclusion

Implementation of this project to our ward has improved bedside clinical hand over according to the results of the nursing and patient survey. Our future focus is to improve goal setting with patients and to extend the improved bedside handover to morning and night shift.

References

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