Improving Patient Safety and Satisfaction With Standardized Bedside Handoff and Walking Rounds

Julia S. Taylor, RN, BSN, BA

In 2009, the Joint Commission identified a standardized approach to handoff communication as a patient safety goal to reduce communication errors. Evidence suggests that a structured handoff report, combined with active patient participation, reduces communication errors and promotes patient safety. Research shows that bedside handoff increases nurses’ accountability by visualizing the patient and exchanging information at the point of care. Based on recommendations from the Joint Commission, the Robert Wood Johnson Foundation, and broader research literature, a standardized approach to bedside handoff and walking rounds was implemented on an inpatient surgical oncology unit.

At a Glance
- A standardized handoff communication tool is recognized as a Joint Commission patient safety goal to reduce communication errors and improve patient safety.
- The benefits of patient safety and satisfaction outweigh the barriers to implementing a bedside handoff report.
- A standardized, nurse-driven, electronic report should guide transfer of information during bedside handoff.

Julia S. Taylor, RN, BSN, BA, is a clinical nurse II at Memorial Sloan Kettering Cancer Center in New York, NY. The author takes full responsibility for the content of the article. The author did not receive honoraria for this work. No financial relationships relevant to the content of this article have been disclosed by the author or editorial staff. Taylor can be reached at taylorj5@mskcc.org, with copy to editor at CJONEditor@ons.org.

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The process of patient handoff during change of shift can unintentionally lead to important information gaps and errors with the end result of patient harm. Handoff reports lacking important standardized information have been directly associated with sentinel events, errors, and near misses among nurses (Staggers & Blaz, 2013). Nursing handoffs occur multiple times on a given day, with some units transferring or discharging 40%-70% of their patient population (Friese, White, & Byers, 2008). In 2009, the Joint Commission identified a standardized approach to handoff communication with the opportunity to ask and respond to questions as a patient safety goal. With the goal of reducing communication errors and improving patient care, the Joint Commission recommended interactive communication during handoff, with up-to-date information about the patient’s condition, including care, treatment, medications, services, and anticipated changes. Other recommendations included opportunities to share and review relevant patient history through read-back techniques in an environment with few interruptions (Joint Commission, 2009).

According to the Joint Commission, the Robert Wood Johnson Foundation recommends the use of an automated end-of-shift report with structured patient information. By incorporating patient handoff with face-to-face collaboration and opportunities to ask questions, hospital units can achieve improvements in efficiency, workflow, and patient safety (Robert Wood Johnson Foundation and Institute for Healthcare Improvement, 2006). In response to recommendations from the Joint Commission, the Robert Wood Johnson Foundation, and broader research literature, a standardized approach to bedside handoff and walking rounds was implemented on a 43-bed colorectal, gastric, sarcoma, and melanoma surgical inpatient oncology unit at Memorial Sloan Kettering Cancer Center in New York, NY, in 2010.

Effective change-of-shift practices are those that maximize the transmission and retention of vital information. A structured, consistent approach to handoff formatting is associated with improved information handover (Pothier, Monteiro, Mookhtar, & Shaw, 2005). In addition, Pothier et al. (2005) concluded that a typed sheet, in combination with a verbal handoff report, resulted in decreased information loss. As recommended by the Joint Commission, some institutions have used standardized handover tools, such as the Situation, Background, Assessment, and Recommendation (SBAR) technique, to guide information transfer. However, Staggers and Blaz (2013) concluded that insufficient evidence exists to
support the use of SBAR or any other specific format for change-of-shift handoffs.

Handoffs should be supported, not replaced, by technology. A patient-centered, nursing-focused, standardized electronic handoff with methods tailored to each unit decreased average times and costs for the handoff process (Nelson & Massey, 2010). When large amounts of information are communicated, short-term memory is limited, creating possible gaps in information. Therefore, an electronic design of handoff should be able to reduce reliance on memory by using preprinted patient information forms that maximize accuracy and completeness of patient data during the handover process (Friesen et al., 2008).

Inadequate patient handoffs have the potential to be associated with sentinel events. Two-thirds of sentinel events in hospitals are related to communication issues, with patient handoff accounting for a large portion of miscommunication (Sand-Jecklin & Sherman, 2015). In a retrospective review of 2,729 patient safety events over a 36-month period at an English hospital, 334 events were identified as handoff-related. Of those 334 events, 45% involved poor-quality or incomplete handoffs and 29% involved completely missed handoffs (Pezzolesi et al., 2010). When nurses and physicians on a pediatric cardiac surgery unit switched to a structured system of handoffs, the unit saw significant reductions in severe complications, including metabolic acidosis and resuscitation events (Agarwal et al., 2012). Similarly, when seven medical/surgical units at a major teaching hospital adopted a formal nursing handoff system, the units achieved improvements in their rates of medication errors and patient falls (Sand-Jecklin & Sherman, 2015).

Patient safety is not the only purpose of effective handoffs. Other benefits can include educational and emotional support, group cohesion, transparency, and relief of anxiety for the nurse and patient (Staggers & Blaz, 2013). Bedside handoff, in particular, can improve patient satisfaction through involvement in care, improved nurse-patient relationships, and reduction of discharge times because of improvements in patient education. For nurses, bedside handoff can increase satisfaction by improving handoff efficiency, teamwork, accountability, and mentorship opportunities between nurses.

Implementation Into Practice

The objective of the author’s evidence-based practice project was to recognize how the implementation of a standardized bedside handoff can improve patient safety and satisfaction on an inpatient surgical oncology unit. A review of the literature was conducted, and survey data from a convenience sample of nurses and patients were gathered.

In 2010, the format of end-of-shift report transitioned to bedside handoff and walking rounds on a 43-bed colorectal, gastric, sarcoma, and melanoma surgical inpatient oncology unit. The decision to change practice was inspired by the 2009 Joint Commission recommendation and nursing administration guidelines for best patient safety practice.

During change-of-shift report, the outgoing nurse prints a standardized medical record handoff addressing diagnosis, comorbidities, activity level, diet, advance directives, vital signs, vascular access, fluids, pain, laboratory results, and a brief summary of the patient’s systematic and psychological concerns. The standardized medical record handoff was developed from the information technology department, with nursing insight. The outgoing and oncoming nurses discuss the printed handoff in a distraction-free environment and, when possible, initiate walking rounds by making an introduction and addressing clinical concerns and questions of the patient and family members. The outgoing nurse is able to visually and personally conclude the shift’s tasks and further clarify nursing needs with the collaboration of the patient and family. The oncoming nurse is able to make an introduction while identifying clinical checks and assessments, such as patient-controlled analgesic settings, correct IV fluids, and pain control management. Patient safety situations, such as fall interventions, toileting needs, and call bell placement, are identified and acted on by the outgoing and oncoming nurse. The nurse-to-nurse and nurse-to-patient handoff interaction typically lasts 3–4 minutes for each patient. Throughout the shift, the oncoming nurse has a tangible and easily accessible record of pertinent clinical data. To continue the process, the outgoing nurse continuously updates the electronic handoff and prints the updated final product for the next oncoming nurse.

Findings and Interpretation

Qualitative data were collected through a survey of a convenience sample of nurses and patients on a surgical oncology unit four years after the new handoff system was implemented in 2010. Through the analysis of survey results, barriers were identified in the implementation of bedside handoff and walking rounds. Walking rounds are not always completed because of unit distractions, such as call bells, phone calls, and prioritization of clinical needs. In addition, compliance barriers of nurses engaging in walking rounds included patient privacy and Health Insurance Portability and Accountability Act concerns, as well as time constraints and varying degrees of workflow interruptions during change of shift.

Twelve of seventeen nurses reported that they were moderately satisfied with bedside handoff and walking rounds. Two nurses reported that they were highly satisfied. The top four self-reported benefits to nurses included introduction to the patient and family at the beginning of the shift, improved communication from nurse to nurse and nurse to patient, improved patient satisfaction and adherence in care, and task prioritization by visualizing the patient. According to patients, the top two benefits of bedside handoff were nursing introductions and enhanced communication.

Some patient safety metrics improved on the unit after the adoption of the new handoff system, but whether these gains were driven primarily by the handoff reforms or by other safety initiatives was impossible to determine. Prior to handoff implementation, in 2009, the unit suffered five falls with injury. Post-implementation, in 2010, the unit only suffered three falls with injury. However, the total number of falls increased from 25 to 29. In addition, medication errors decreased from 32 errors in 2009 to 27 errors in 2010.

Discussion

Based on the reviewed literature and clinical implementation of bedside handoff and walking rounds, a change-of-shift
report at the bedside through the use of standardized electronic handoff promotes a cohesive atmosphere of patient safety and satisfaction. This nurse-driven intervention to improve patient safety and satisfaction continues to promote quality patient care and safety while maximizing effective communication. The positive effect that bedside handoff and walking rounds have on patients, families, nurses, and other clinical staff outweighs the barriers of implementation. Additional research should explore how patient involvement and interaction in the handoff process affect anxiety and call bell usage. In addition, research should continue to examine the relationship between handoff formats and patient harm, error detection, and general patient satisfaction.

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References


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