

# Patient Safety Outcomes with Bedside Reporting

Karen Butkievich, RN BSN

Megan Hopkins, RN

## Introduction

- This EBP project was started in response to patient safety events reported that could have been prevented had nursing staff completed change of shift hand off at the patient's bedside. A few commonly found events included lack of a patient ID or allergy bands, IV medications not properly infusing, and bed alarms not engaged.

## Inquiry, Purpose

**Problem:** Patient safety errors found after hand off completed not at the patient bedside.

**Inquiry:** Do Progressive Care inpatient populations see a decrease in safety patient errors with bedside handoff versus handoff completed at the nurse's station away from the patient?

**Purpose:** Decrease PSN reports with implementation of increased bedside nursing handoff

LOE I	LOE II	LOE III	LOE IV	LOE V	LOE VI	LOE VII
0	0	3	1	1	0	0

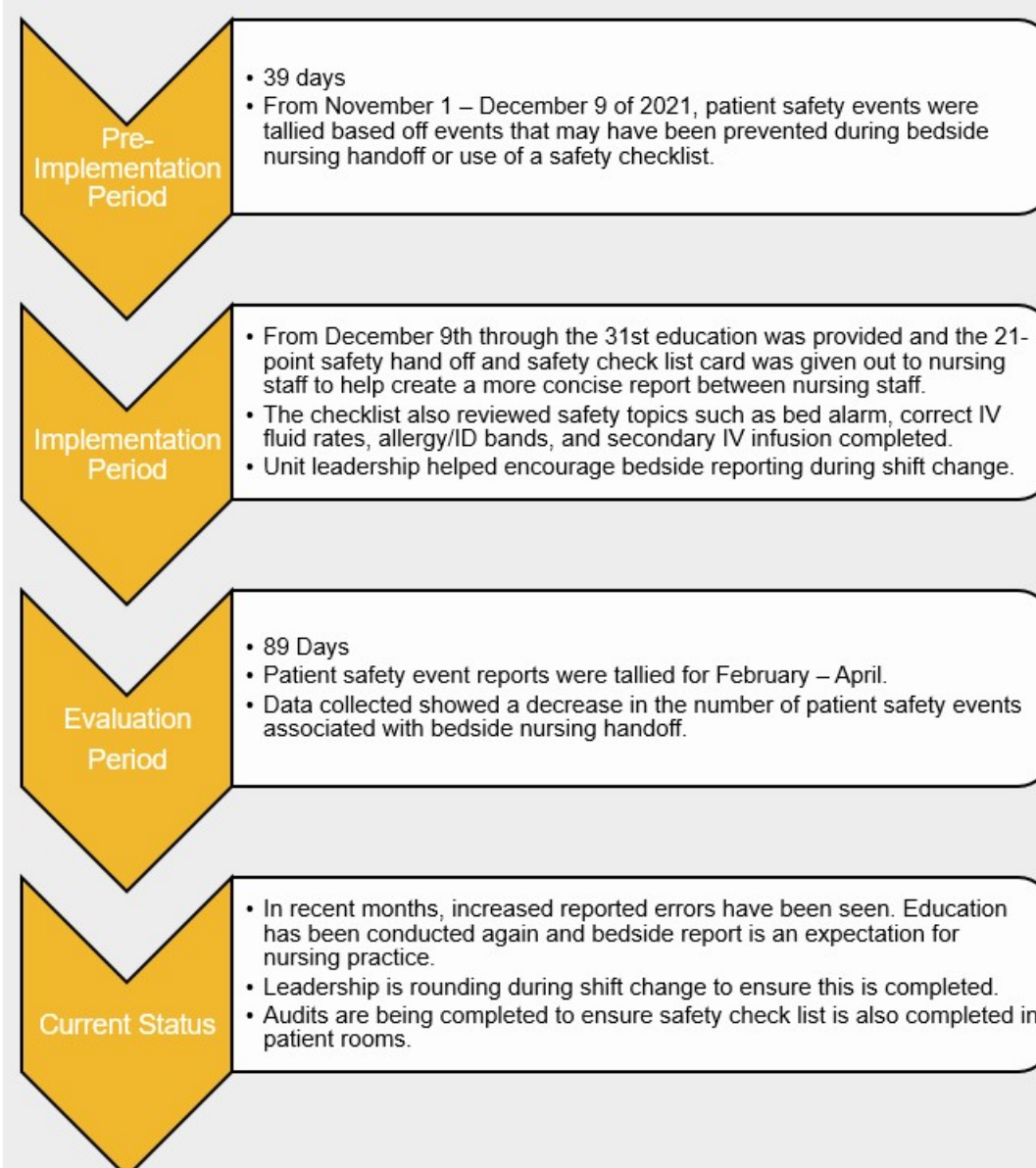
## Synthesis of Evidence

**Databases searched:** CINAHL, EBSCO, PubMed

**Keywords:** bedside reporting, nursing handoff, patient safety, reducing errors, communication tools, best practice

**Themes:** Articles were selected by reviewing the abstract content, outcomes identified, data collected in the study, and both qualitative and quantitative measurements. Ten articles were originally found and 5 were used. The literature supports bedside reporting, highlighting the importance of a thorough hand off between nursing shifts. Cairns et al. (2013) implemented a project focusing on bedside hand off and the unit saw a decrease in falls by 24% and improved nursing satisfaction. Manges and Groves (2019) found that nurses feel more prepared for their day with the use of bedside reporting, and it allows patients to feel more involved in their care. Rhudy et al. (2022) discussed the importance of a clear, concise, and consistent report structure which improves hand off and highlights critical components to patient care. In addition, bedside reporting increases peer-to-peer accountability among nurses.

## Methods



## Setting, Participants and Time

- This project was conducted in a 30-bed inpatient Progressive Care Unit at a large academic medical center.
- The target population for this project consisted of the nurses who care for patients on the Progressive Care Unit.
- The project was discussed and planned for September and October 2021.
- Data was collected during November – early December. Education was provided during the months of December and January. Data was collected for February – April and results were discussed in May of 2022.

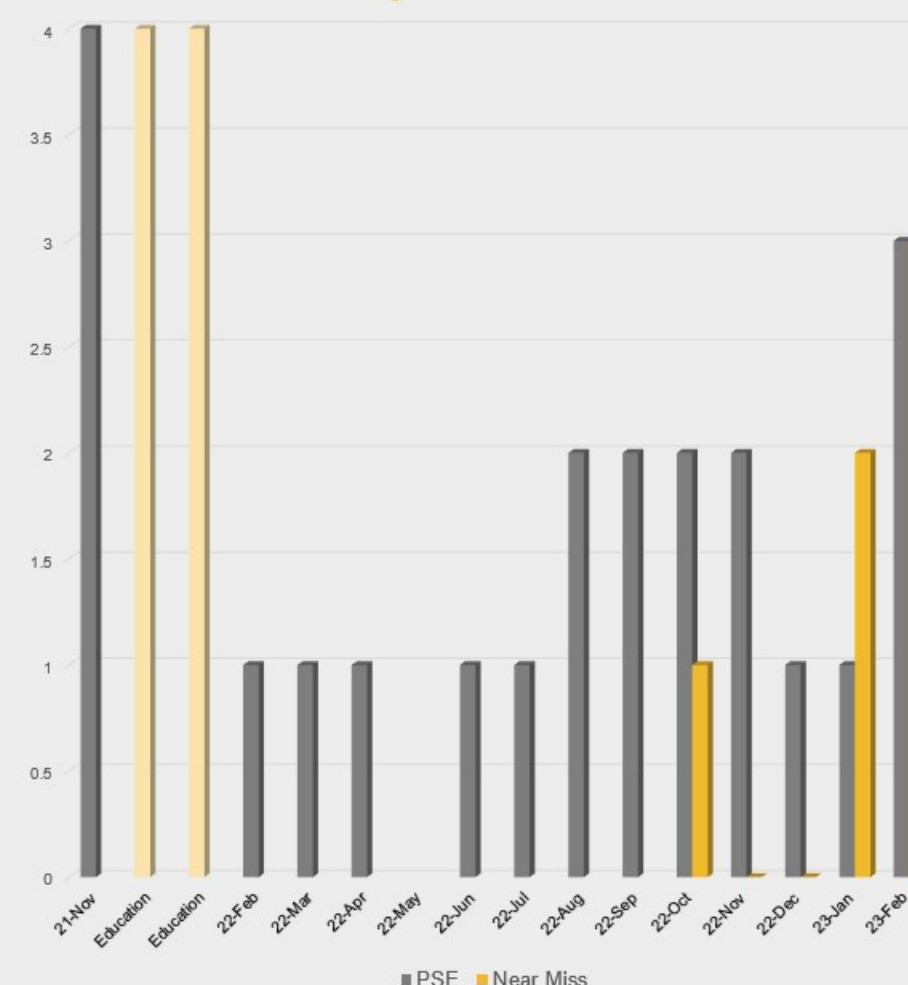
## Intervention

- During the implementation period, staff and leadership created and laminated 21-point hand off cards and safety checklists for each staff member. Verbal discussion and huddle messages occurred to reinforce education.

## Results

- Data collected showed a decrease in the number of patient safety events associated with bedside nursing handoff. During the 39-day pre-implementation period the unit had 4 events, revealing a 10.26% chance of event per day. The 89-day post implementation period saw a decrease to 3 events occurred which improved the chance of events per day to 3.37%.

Patient Safety Event and Near Misses



## Instruments and Outcomes

### Revised 21 Point Report:

- Name
- Age
- Service
- Current diagnosis
- Pertinent history
- Allergies (food, drug, or other)
- Neuro (pupils, pain, orientation)
- Respiratory (oxygen, trach, treatments)
- GI (diet, drains, last BM, assistance with feeding)
- GU (voiding, Foley, anuric)
- Cardio (rhythm, murmur, pacer)
- Skin wound skeletal system (dressings, splints, braces, traction, spine clear/log roll, HOB restrictions)
- Procedures (tubes, drains, incisions)
- Lab (pending or completed, abnormal, accu-checks)
- IV access (peripheral or central)
- IV drips (rate, access verified)
- Activity fall risk (how pt. gets up, assist needs, fall this hospitalization)
- Special needs psychosocial (disability, lives in facility, fall precautions, restraints)
- Teaching/special instructions
- Family contact/issues
- Discharge plan/update

### Bedside Report Visual Checks

- Check bed
  - Patient in bed,
  - bed in low position
  - I/BD is on/green
  - Bed alarm set
- Check armbands
  - ID
  - Allergy
  - DNAR/LOT
  - Limb alert
  - Blood band
- Check Monitors
  - Telemetry connected
  - SpO2 reading
  - Oxygen flow
- Check IV Medications
  - Clarify issues/unclear instructions
  - Verify rate/dose
  - Count PCA
- Check drains/tubes/wounds
  - Verify output
  - Visualize drains/lines/wounds/tubes
  - Clarify maintenance (flushes, dressing changes, tube feed orders etc.)
- Check safety
  - Suction set up
  - Ambu Bag
  - Trash emergency bag
  - Call light within reach
- Update your name/number on whiteboard and door.

## Conclusion

### Discussion

- Results were shared at the next unit council meeting in May of 2022 among nursing staff to help educate, support, and continue this practice on the unit. During September 2022, physical copies of the checklist were placed in patient rooms for nursing to sign during hand-off at the change of shift. This helps hold each shift accountable for patient safety measures.

### Limitations

- Barriers to this project included staff participation, increased length of time of report and time constraints to complete the safety check list. The lack of patient care staff support during report also created a barrier.

### Healthcare Implications

- The return on investment for the organization includes improved patient outcomes with decreased patient safety errors through proper bedside nursing hand off and usage of a safety check list. In addition, the investment includes a more concise, efficient, and consistent bedside reporting system, as well as accountability for each shift to ensure proper safety measures for patients.

### Future Application

- Audits are conducted periodically by unit leadership to ensure the check list is completed and that bedside report is occurring at change of shift.

## References

- Cairns, L.L., Dudjak, L.A., Hoffman, R.L., & Lorenz, H.L. (2013). Utilizing bedside shift report to improve the effectiveness of shift handoff. *Journal of Nursing Administration, 43*(3), 160-165. doi:10.1097/NNA.0b013e318283de02
- Manges, K. A., & Groves, P. S. (2019). Exploring the Hidden Functions of Nursing Bedside Shift Report. *Journal of Nursing Care Quality, 34*(3), 256–262. <https://doi.org.proxy.mull.missouri.edu/10.1097/NCQ.0000000000000357>
- Boersma, K. C. M., & Freeman, M. C. (2022). Effective nurse handoffs: Key considerations for design and implementation. *Nursing, 52*(4), 51–54. <https://doi.org.proxy.mull.missouri.edu/10.1097/01.NURSE.0000823256.78368.d7>
- Martini, A., & Resek, J. (2021). A Practical Guide to the Implementation of Bedside Report in a Critical Care Setting. *Critical Care Nursing Quarterly, 44*(3), 324–333. <https://doi.org.proxy.mull.missouri.edu/10.1097/CNQ.0000000000000368>
- Lori M. Rhudy, Maren R. Johnson, Catherine A. Krecke, Danielle S. Keigley, Sarah J. Kraft, Pamela M. Maxson, Sharon M. McGill, Karen T. Warfield; Standardized Change-of-Shift Handoff: Nurses' Perspectives and Implications for Evidence-Based Practice. *Am J Crit Care 1 May 2022; 31* (3): 181–188. doi: <https://doi.org/10.4037/ajcc2022629>