Standardized Bedside Report During the Transfer of Care

Evidenced Based Benchmark Study

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Importance

- In surgical services specifically, multiple patient transfers can happen in a short amount of time, increasing the opportunities for communication failures significantly.
- This increases with each subsequent handoff, creating a potential for critical data to be missed and serious safety events (The American Society of PeriAnesthesia Nurses [ASPAN], 2016).
- Joint Commission (2017) has identified that communication failure is a contributing cause to sentinel events in the hospital setting.

PICOT Question

“In staff nurses on a pediatric surgical unit (P), how would a standardized bedside report during the transfer of care (I) compared to standard procedures for transfer of care (C) affect omission of patient information (O) at 8 weeks after implementation (T)?”

Review of Literature

- In the perioperative setting where multiple handoffs can occur in a short amount of time and Salzwedel et al., (2013) reported that the use of standardized reports increases the amount of patient information items that were handed over during transfer of care. Salzwedel et al., (2013) randomized control trial study, appropriate use of the standardized report form showed an increase in patient information items being handed off significantly
- Scheidenhelm & Reitz (2017) studied nursing compliance before and after the implementation of the standardized bedside report, showing an increase in nursing compliance to be significant. Scheidenhelm & Reitz (2017) also studied that patient satisfaction about communication increased significantly with question of “nurses kept you informed.”

Review of Literature

- Mehta et al., (2018) studied how the use of standardized checklists could help reduce the amount of complications post surgical intervention. Overall, this quasi-experimental study concluded that "implementation of SURPASS checklist is effective in reducing the rate of postoperative complications in both elective and emergency surgeries" (Mehta et al., 2018, p. 1).
- Halterman et al., (2019) conducted a quality improvement project aimed to decrease the amount of patient information that can be omitted during the postanesthesia care unit (PACU) patient handoff. The study resulted not only in a decrease in patient information omission, but also, showed increased compliance with the report process between nurses

Review of Literature

- Three themes were identified: "barriers to conducting bedside report, patient safety, and impact on patient care" (Bigani & Correia, 2018, p. 85). By the end of this study, nurses reported that preferred this method of change-of-shift communication practice. Because of this, Bigani & Correia (2018) supports using bedside report during transfer of care between nursing staff.

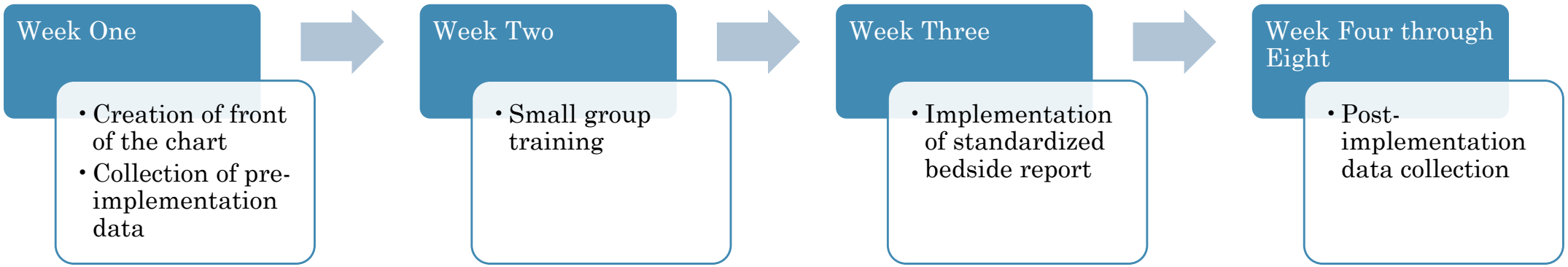
Stakeholders

- Patients and families
- Bedside nursing staff
- Advanced Care Technicians
- Certified Registered Nurse Anesthesiologist (CRNA),
- Medical Doctor of Anesthesiology (MDA)
- Medical Doctor (MD)
- Nursing Leadership/Management
  - Mid level – nursing unit manager
  - High level – Chief nursing office, AVPs, nursing directors

Goals and Evaluation

- The overall goals of this project include
  - Decrease length of handoff time from admit to Phase II to RN handoff is completed
  - Improve registered nurse (RN) workflow as evidenced by decreased time to first documented RN assessment and improved perceptions of nurse workflow
  - Improved patient/family satisfaction scores. the handoff time was defined as the time patient was admitted to the Phase II unit until the nurse-to-nurse handoff was completed.

Timeline


Week One
• Creation of front of the chart
• Collection of pre-implementation data
Week Two
• Small group training
Week Three
• Implementation of standardized bedside report
Week Four through Eight
• Post-implementation data collection

Data Collection

- Completion rate of bedside report form (form seen in Appendix A)
- Nurse satisfaction/perception scores from survey
- Patient satisfaction scores from NRC database
- Physical assessment times.

Conclusion

- With communication errors being correlated to sentinel or adverse events during patient care, it is important to continuously assess and improve current communication practices.
- Evidence has showcased that the use of standardized reports at the bedside is the new standard when communicating patient information with nursing staff, patients, and families.
- Collaboration between bedside nurses, charge nurses, and nursing leadership, practice changes in communication can be implemented to ensure we provide the safest, evidence-based care.

References

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Appendix A

Preferred Name:_____

Preferred Language:_____

Preop B/P:_____

Age: _____

Weight: _____

_____

Cup/Bottle/Sippy/G-Button/Breast/Brought

Chart Checking

- ☐ Consents Initials:_____
- ☐ H&P Initials: _____
- ☐ Schedule Initials:_____
- ☐ Risks Initials: _____
- ☐ Teaching Initials: _____

NPO/Void/HCG

- ☐ Solids_____
- ☐ Breastmilk _____
- ☐ Clears_____
- ☐ Last Void_____
- ☐ HCG +/- (Circle One)

Notes/Comments:

Brought by:_____

PACU @ _____

OR Circulator: _____

CRNA: _____

BP:
HR:
RR:
Temp:
O2:

Procedure:

Wounds/Incision/Dressing:

Take Home Meds

- ☐ Drops sent/ Ointment Sent

Pre-Med: NV POV IVV Mask

MDA: ASA:
Pertinent History:

ETT: mm @ cm

IV size/Location: ____g RT/LT _____
IV Fluids
In OR _____ ml
In Phase I _____ ml to count
Phase II: _____ ml to count

Meds	OR	P1	P2
Fentanyl			
Morphine			
Dex.			
Zofran			
Tylenol			
Toradol			
Neb			

Additional medications ordered:
Complications in OR:
Extubation Time:
PO fluids offered: _____ ml

Bedside Report Completed:

_____ and _____