Standardization in Bedside Shift Report

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BACKGROUND / INTRODUCTION

- **Project Purpose:** To develop an emergency room specific nurse to nurse patient care hand off tool that increases compliance in fall risk, utilization of SBAR tool, use of communication boards, and bedside shift report.
- **The Joint Commission** (TJC 2006) has reported that nearly 70% of sentinel events can be traced to breakdowns in communication.(SBAR) The Joint Commission developed a patient safety goal to improve communication among caregivers using a standardized approach to handoff communication, with particular attention to providing the opportunity for asking and responding to questions.

METHODS/IMPLEMENTATION

- Carry out a survey to view how the staff nurses feel about bedside shift report and care hand off by performing a pre/post implementation survey.
- Educate all ED RNs of the standardized SBAR tool
  - Place on agenda for Monthly Staff Meeting
  - Include in Monthly 1:1 Education by Education/ Practice Council
  - Create a TLC for all ED nurses to complete
- Utilizing a standardized nurse to nurse hand off tool at the bedside during shift report, to ensure that all aspects of the patients care are met

- To continue to implement the use of the bedside communication boards to help communicate patient goals, treatment plan, pain scale, etc.

OUTCOMES

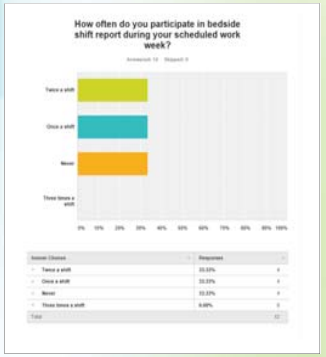
- Increased compliance for SBAR report fall risk
  - Monthly quality data measurement
- Increased compliance for use of communication boards
  - Daily management board data
- Increased compliance of bedside shift report
  - Daily management board data

Barriers

- Nursing handoffs that are inaccurate, misinterpreted, omitted, incomplete or biased may lead to a failure to recognize and prevent serious patient harm (SBAR article).
- Incongruence between the description of patient condition during report and actual condition found after the report.
- Nurses do NOT follow a standardized report but do follow ritualized habits that negatively affect patient care.

Strategy to Overcome: Standardizing a shift report and having the nurses give report at the bedside will help to reduce bias and allow patients to participate in their care. Will also allow for the nurse taking over care to visually assess the patient as report is given

RESULTS



CONCLUSIONS

The development and implementation of an ED specific nurse to nurse patient care hand off tool does improve compliance of SBAR, fall risk, utilization of communication boards and bedside shift report

While we implemented and created a standardized SBAR tool for the Emergency Department, the hospital is working on initiating a networkwide bedside shift report specific to each unit, which all nurses will be expected to utilize and follow during shift change. Our project is just the begining of a network wide culture change in regard s to the way nurses view and participate in bedside shift hand off.

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