Bedside Shift Report in the Emergency Department

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BACKGROUND

- The risk for miscommunication between nurses during handoff is heightened in the ED
  - Due to variation of patient acuity, frequent shift changes, and pressure to move patients through quickly (White-Trevino & Dearmon, 2018).
- According to the Joint Commission, communication errors were the main reason for sentinel events (Campbell & Dontje, 2019).
- Handover performed at the bedside enhances patient-centered care by reducing care fragmentation, miscommunication-related adverse events, readmissions, duplication of services (Mardis et al., 2016).

P I C O

- In Emergency Department patients, does the addition of bedside change of shift reporting compared to no bedside shift report impact patient satisfaction and communication with nurses?

EVIDENCE

- SBAR is an evidence-based standardized process that is used to mitigate risk of miscommunication during transition of care at shift change (White-Trevino & Dearmon, 2018).
- Nurses like the concept of SBAR due to being able to hold each other accountable for discussing and completing the patient care plan (Campbell & Dontje, 2019).
- Patients perceive that handover at the bedside enhances their individual care and provides them opportunity to contribute to and clarify information (Kerr et al, 2014).
- Patients feel a more trusting-caring relationship (White-Trevino & Dearmon, 2018).
- It has been shown that bedside shift report decreased falls, medication errors, and restraint use (Mardis et al, 2016).

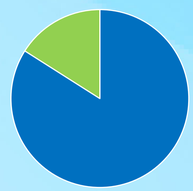
OUTCOMES

- Following the implementation of bedside shift report, 25 nurses responded to the survey with the following results:

I am satisfied with the current method of bedside shift report.

I believe all nurses provide complete and accurate bedside shift report.

I believe bedside shift report "debriefs" me after a stressful shift.



- During the COVID-19 pandemic, bedside shift report was not feasible due to increased exposure risk. Therefore, patient satisfaction measurements were not able to be accurately obtained within the window of time that bedside shift report was implemented.

IMPLEMENTATION

- Nursing satisfaction survey filled out by ED nurses post implementation of beside shift report in ED.
- TLC module educating ED nurses on bedside shift report.
- Handouts on SBAR tool for nurse-to-nurse handover provided for ED nurses.
- Review HCAHPS scores for patient satisfaction post implementation of bedside shift report.

NEXT STEPS

- Maintain nurse and patient involvement in bedside shift report.
- Implement usage of whiteboards to involve patients in their care.

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