eWIN Workforce Information Network

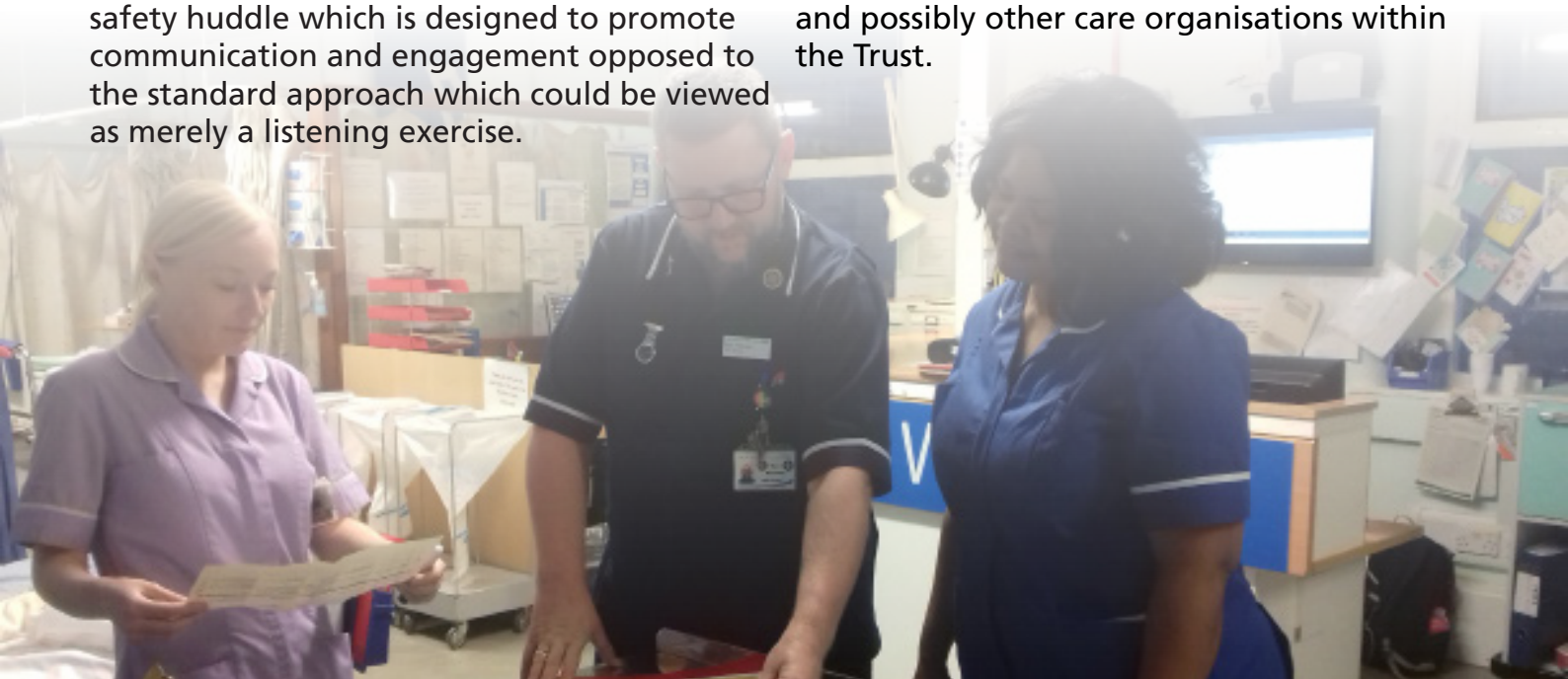
NHS Health Education England

Case Study: An innovative approach to bedside handovers

Throughout 2018 the wards at Pennine Acute NHS Trust have been encouraged to adopt the process of "Bedside handovers". Pearce (2018) describes this as communication at the bedside, giving patients a chance to ask questions and be heard. Adopting this process has proved challenging and staff have experienced uncertainties around sharing of sensitive information, protecting privacy, how to involve patients and ultimately how to use it effectively to improve staff and patient experience.

Ward C3 at North Manchester General Hospital (NMGH) has formulated a structured process to assist this initiative led by the Ward Sister Nicola Aliu with support from the Quality Nurse Janet Clegg and the Quality Improvement Team at Pennine. The process utilises a supplementary handover sheet (see Appendix 1) detailing all elements of the safety huddle which is designed to promote communication and engagement opposed to the standard approach which could be viewed as merely a listening exercise.

The handover sheet is used to record information from the safety huddle and is correlated at the bedside to ensure patient information is relevant and up to date. Bedside documentation is also reviewed by the team and care discussed and planned with patients as appropriate. This process allows sensitive information to be shared with all the team away from the bedside ensuring all staff have a detailed overview of all the patients on the ward. Staff then separate to take bedside handover for their cohort of patients on that particular shift. To support the process, alterations were required to be made to visiting times on the ward to ensure complete confidentiality during the handover process and this has been accommodated whilst maintaining the flexibility of open visiting. This change of practice has highlighted several benefits and there are plans to roll it out across the surgical division, and possibly other care organisations within the Trust.



Key Outcomes

The following benefits have been noted

- Improved communication with patients which has been noted through family and friends feedback

- Accuracy of safety huddle and correlating patient information displayed at the bedside. This has been demonstrated through Quality Assurance audits

- Timely completion and review of Risk Assessments which has been monitored through the electronic systems dashboard

- Improved staff engagement which has been evidenced through pre and post change questionnaires and discussions

Background

The Pennine Acute Hospitals NHS Trust and Salford Royal NHS Foundation Trust have joined together to create a new group of hospitals to deliver a variety of local healthcare services.

This group is being developed to fully align and be consistent with the priorities of the strategic themes of the Greater Manchester Health and Social Care Partnership. It will develop new ways of working that will ensure patients receive consistently high standards of care.

There are 4 Care Organisations in the group:

- Salford Royal Hospital
- North Manchester General Hospital
- Bury and Rochdale Hospitals
- The Royal Oldham Hospital

Many hospitals are reverting back to handovers at the patient's bedside with a view to support patient centred care. However, there is a lack of robust governance that is characteristic of other elements of nursing practice (Pearce, 2018).

The initiative of bedside handover was relaunched recently within Pennine Acute NHS trust which has been promoted from a divisional level. Within a large Trust there has been a diverse approach to implementation with no formal structured guidance. Whilst it is not practical to standardise the approach, as different areas have different needs, this handover document forms a basis for other areas to revise and tailor make for effective use within their speciality.

Key Aims

The aims of this initiative were

- To improve quality and timely documentation
- To improve patient experience by providing an opportunity to be directly involved in discussions surrounding their care
- To ensure the safety huddle and risk assessments replicate the same information and are up to date
- To improve communication within the team and develop meaningful communication for handover of care
- To review charts, for example fluid balance and physiological observations, and ensure they are relevant and up to date
- To ensure appropriate referrals are completed at the earliest opportunity
- To promote individualised and patient centred care

Key Stages of Set-up

When bedside handover was initially introduced there was no formal guidance, staff were not engaged with the process, essential information was missed and it appeared the handover had merely moved from the office to the bedside. Furthermore there were variations in how staff and wards approached bedside handover, all of which questioned the rationale for change. Indeed the initial approach resulted in little benefit for both the patients and the staff.

In adopting a proactive approach ward C3 at NMGH devised a supplementary template to assist with the completion of bedside handover. This was undertaken as a Quality Improvement test of change. Staff views were taken on board via surveys, ensuring that opinions were listened to and acted upon, ultimately helping towards the achievement of a shared goal.

After 8 weeks of trialing the new format, staff feedback was collated. Nurses are now more positive about the bedside handover, and can clearly see the value in it. Patient experience has also seen an improvement and this has supported the ward in achieving safe and effective care.

Improvement in timely completion and reviews of risk assessments has been monitored via the electronic dashboard, this has indicated significant improvement which in turn has assisted the wards improvement work around the nursing assessment and accreditation framework (NAAS).

The change in practice received managerial support from both the Lead Nurse Gail Tann and the Ward Manager Marc Richards. The junior sister led the change with the support of the divisions Quality Nurse. This team approach was pivotal to the success of effective implementation, revision and evaluation. Furthermore it is envisaged that this will assist in standardising the process within the surgical division.

How it Works

The practice change consists of a handover form (see Appendix 1) that is a basic tool designed to accommodate tick boxes to ensure the process is quick and easy to follow. It is divided into sections for each topic, mirrors the safety huddle and identifies interventions that need to be carried out for individual patients. The form is divided into red and black sections. The red sections are used at the bedside to check all charts and documentation are up to date and the black sections are used throughout the rest of the shift to prompt interventions that are needed for the patient. For example, if an individual is identified as having a cognitive impairment at the safety huddle the cognitive impairment box will be ticked and then on approaching the bedside the red parts of the form used to ensure that the bedside board is up to date with the corresponding magnet/ symbol. Visual checks are made to ensure the patient identification/alert band is in place which alerts staff to cognitive impairment and any associated bedside forms, for example the cognitive impairment pain assessment tool. The black areas would then be used throughout the rest of the day to ensure the remaining sections are completed such as Deprivation of liberties in place, Mental capacity assessments, This is me etc. The form embeds information correlating to bed numbers and Do Not Attempt Resuscitation (DNAR) status, National early warning score (NEWS), when observations are next due and if the patient is nil by mouth. The form also consists of a notes section to write any information required for that patient (see Appendix 1).

In line with the deteriorating patient collaborative the cardiac arrest role allocations are identified at the start of the handover and the nursing team document their own role on the handover form. A health care support worker team lead is also identified to support all areas of the form e.g. fluid balance, food charts etc.

The form does indeed serve as a useful reminder of all mandatory documents that need to be reviewed and discussed at the bedside. However, it must be acknowledged that when undertaken correctly the process of bedside handover offers many other benefits. Essentially it affords a valuable opportunity to introduce each patient to the team caring for them, ensure they have access to call bells and personal belongings and involve them with discussions pertaining to their care where appropriate. Experience has shown that patients value this, often taking the opportunity to ask questions, participate in decision making and outline "what matters to them" that particular day.

> **"It is nice that we feel we are involved and kept up to date with what is happening"**
>
> Patient

> **"I like the bedside handover - I can ask questions and have more of an idea what is going on"**
>
> Patient

Resources

The project did not require any funding to initiate other than an extra handover sheet. However in the initial phase time needed to be invested and the process required support from the Lead nurse and Quality nurse. The project had further backing from the quality improvement team with a view to adopting it Trust wide if a success.

The Lead Nurse and Quality Nurse undertook independent observations of the handover providing an opportunity to identify early problems, review the change observe staff and patient interaction and provide constructive feedback to the team.

This change in practice was initiated by the junior sister, however the Ward Manager has been pivotal to its success. Having entrusted leadership he allowed the team to own the change. Although he made time to listen to concerns he remained impartial allowing the Ward Sister to lead, review the process and make the necessary changes.

Key Challenges

- Change of practice - to address this all staff were involved with the project from the offset and questionnaires were handed out prior to the implementation of the new structure. These were then reviewed at 8 weeks (see Appendix 3). Staff were reassured that this was a test of change and additional ideas and changes were welcomed. The questionnaires indicated that whilst the team were positive pre change about their current handover they acknowledged the new approach improved safety and promoted patient centred care.

- Increased time to handover - this was only an issue in the short term whilst staff adapted to the new way of working.

- Education - all staff needed to be educated on the new documentation. This was communicated via a communication board displayed in the staff room (see Appendix 2). Support was also provided by the Sister, Quality Nurse and Lead Nurse during the initial stages who periodically undertook observations of practice.

Key Learning

- Changes were made to the initial layout of the form to ensure it followed the order of documentation at the bedside, making it more user friendly

- Initially the forms were used as separate entities but staff were finding it difficult to navigate the forms and asked for them to be stapled together making it easier to use

- Staff were initially taking iPads on bedside handover to access patient track to check a patient's observations. This process took time and was replaced by staff on the existing shift filling out the NEWS section and when observations were due to be checked. Notes on what the patient was scoring on were added to the notes section of the form to be used if required

Sustainability

As with any change implementation, this took time and perseverance - when busy and under pressure appeared easier for staff to revert back to old practice. However, due to unannounced observations these issues were highlighted in a timely manner and plans put in place for support. During this time staff themselves noted that things were being missed and came to realise the positive effect the tool was having when used consistently and correctly. This made the implementation of the form easier to sustain.

It has to be acknowledged that issues arise with agency workers and new nurses who are unfamiliar with Ward C3 process. Consequently extra time is needed to brief and support the individuals prior to handover. The disadvantage of this is the extra time handovers take. It is anticipated this will improve once the form is rolled out throughout the trust.

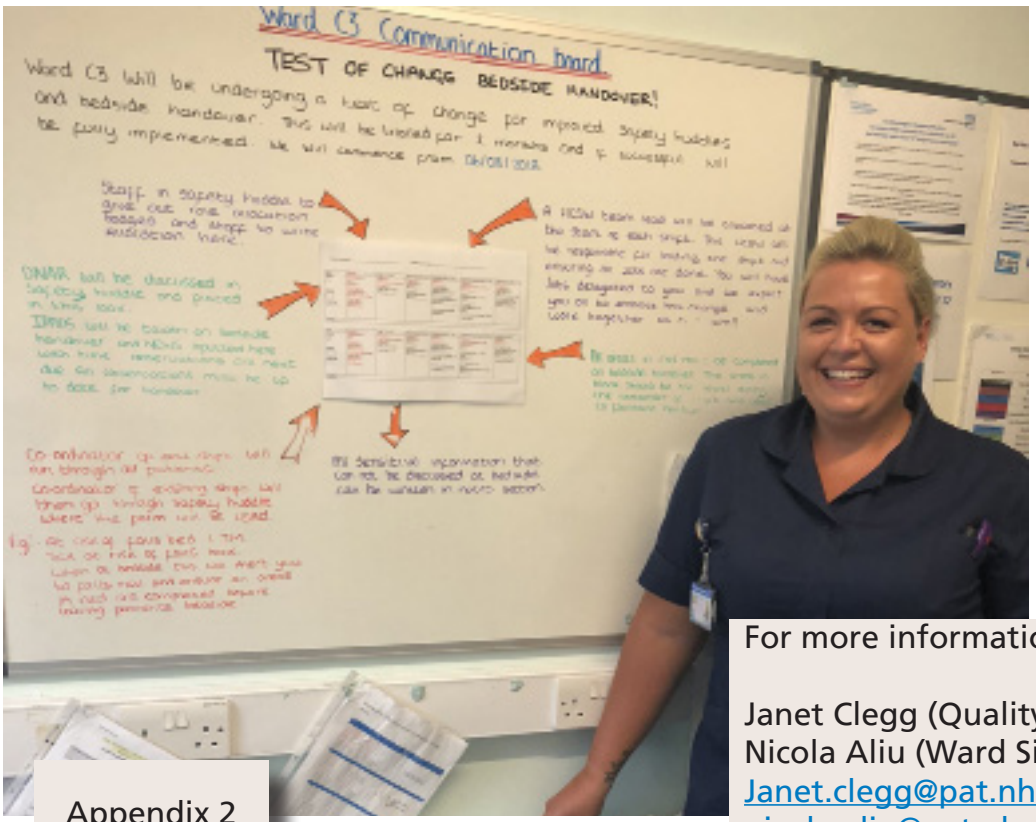
Next Steps

- To roll out the form to other surgical wards followed by the other divisions and potentially other care organisations within the Trust
- Completion of standard operational procedure to standardise the process.
- Formal presentation within the Trust and to external interested parties
- Review document as required in line with new initiatives.

Supporting Material

- **Appendix 1** – Handover sheet
- **Appendix 2** – Communication board
- **Appendix 3** – Audit tools/ questionnaires for staff

Pearce, L. (2018). 'Making handovers more effective', *Nursing Standard,* vol 33, no 9, pp. 42-44.



Appendix 2

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