

Improving Patient Safety and Satisfaction With Standardized Bedside Handoff and Walking Rounds

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In 2009, the Joint Commission identified a standardized approach to handoff communication as a patient safety goal to reduce communication errors. Evidence suggests that a structured handoff report, combined with active patient participation, reduces communication errors and promotes patient safety. Research shows that bedside handoff increases nurses' accountability by visualizing the patient and exchanging information at the point of care. Based on recommendations from the Joint Commission, the Robert Wood Johnson Foundation, and broader research literature, a standardized approach to bedside handoff and walking rounds was implemented on an inpatient surgical oncology unit.

At a Glance

- A standardized handoff communication tool is recognized as a Joint Commission patient safety goal to reduce communication errors and improve patient safety.
- The benefits of patient safety and satisfaction outweigh the barriers to implementing a bedside handoff report.
- A standardized, nurse-driven, electronic report should guide transfer of information during bedside handoff.

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The process of patient handoff during change of shift can unintentionally lead to important information gaps and errors with the end result of patient harm. Handoff reports lacking important standardized information have been directly associated with sentinel events, errors, and near misses among nurses (Staggers & Blaz, 2013). Nursing handoffs occur multiple times on a given day, with some units transferring or discharging 40%–70% of their patient population (Friesen, White, & Byers, 2008). In 2009, the Joint Commission identified a standardized approach to handoff communication with the opportunity to ask and respond

to questions as a patient safety goal. With the goal of reducing communication errors and improving patient care, the Joint Commission recommended interactive communication during handoff, with up-to-date information about the patient's condition, including care, treatment, medications, services, and anticipated changes. Other recommendations included opportunities to share and review relevant patient history through read-back techniques in an environment with few interruptions (Joint Commission, 2009).

According to the Joint Commission Center for Transforming Healthcare (2014), *patient handoff* is a real-time

transfer and acceptance of patient information from one caregiver to another to ensure the continuity of patient safety. The Robert Wood Johnson Foundation recommends the use of an automated end-of-shift report with structured patient information. By incorporating patient handoff with face-to-face collaboration and opportunities to ask questions, hospital units can achieve improvements in efficiency, workflow, and patient safety (Robert Wood Johnson Foundation and Institute for Healthcare Improvement, 2006). In response to recommendations from the Joint Commission, the Robert Wood Johnson Foundation, and broader research literature, a standardized approach to bedside handoff and walking rounds was implemented on a 43-bed colorectal, gastric, sarcoma, and melanoma surgical inpatient oncology unit at Memorial Sloan Kettering Cancer Center in New York, NY, in 2010.

Review of the Evidence

Effective change-of-shift practices are those that maximize the transmission and retention of vital information. A structured, consistent approach to handoff formatting is associated with improved information handover (Pothier, Monteiro, Mooktiar, & Shaw, 2005). In addition, Pothier et al. (2005) concluded that a typed sheet, in combination with a verbal handoff report, resulted in decreased information loss. As recommended by the Joint Commission, some institutions have used standardized handover tools, such as the Situation, Background, Assessment, and Recommendation (SBAR) technique, to guide information transfer. However, Staggers and Blaz (2013) concluded that insufficient evidence exists to