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Patients' Perceptions of Bedside Handoff

Further Evidence to Support a Culture of Always

CE 2.0 Contact Hours

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Patients' perceptions of satisfaction, understanding, participation, and feelings of safety were significantly correlated with the frequency of bedside handoff. Mean responses to survey items in these areas were significantly higher for patients who "always" experienced bedside handoff than for those who experienced it sporadically. Quality improvement strategies were effective in increasing the frequency of bedside handoff. **Key words:** *bedside handoff*, *bedside report*, *communication*, *handoff*, *handover*, *quality improvement*

HANDOFFS, the transfer of responsibility for patients' care from one provider to another, are a potential source of communication errors for hospitalized patients.[1] They are frequent occurrences in health care settings, happening when patients move from unit to unit within one facility, when patients are moved from one level of care to another, and when patients remain in one setting but providers change shifts. Handoffs are important communication points for both patients and providers.[2] Both The Joint Commission[3] and the World Health Organization[4] have acknowledged the risk of errors at handoffs and provided suggestions for improving handoffs.

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The literature base on handoffs has expanded and has implications for care providers and patients. Historically, handoffs by nurses were conducted in a conference room or nurses' station, away from the patient. Conducting these handoffs at the patient's bedside has been adopted increasingly in health care facilities over the past decade. Benefits for patients include improved patient satisfaction, improved patient understanding, increased participation in care, and enhanced patient safety.[3,5,6]

In a previous study on 2 inpatient units, we found significant positive correlations between the frequency with which patients experienced bedside handoff and their perceptions of their care. Specifically, patients' perceptions and understanding of and participation in their care, as well as their safety and satisfaction, were increased when they participated in bedside handoffs more frequently.[7] This article reports the results of a replication study examining the perceptions of patients throughout the entire medical-surgical division of the hospital in which the pilot study took place. Specifically, we sought to validate that patients' satisfaction with the handoff, understanding of their care, feelings of safety, and satisfaction with the handoff process were associated with the frequency with

which they experienced bedside handoffs. In addition, we assessed patients' perception of whether they felt included in the handoff process and how often they reported participation in the handoff. We also examined the effectiveness of quality improvement efforts on sustainability of the practice of bedside handoffs on the pilot study units.

LITERATURE REVIEW

For nurses, the end-of-shift handoff provides an opportunity to pass on and receive information that is essential to managing the patient's care for the oncoming nurse. Nurses have reported an increased ability to appropriately prioritize care and an increased focus on patient-centered care as a result of implementing bedside handoffs.[3,8] Bedside handoffs also have been found to influence several aspects of patients' perspectives of their care including satisfaction, understanding of care, participation, and feelings of safety.

In settings in which patient satisfaction was evaluated before and after the implementation of bedside handoffs, overall patient satisfaction scores and satisfaction with the handoff process improved. Cairns et al[9] noted improvements in proprietary patient satisfaction scores after implementation of bedside handoff. Improvements in Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS) scores and on a validated patient survey were documented after bedside handoff was put into practice in several settings.[6,10,11]

When nurses hold the end-of-shift handoff away from the bedside, patients have reported that they feel unable to reach someone and expressed concerns that they would not be able to get help if they needed it. When bedside handoffs were implemented, patients reported higher levels of satisfaction with being kept informed and also reported that they could keep their family members informed of what was going on with them.[9]

In addition to improvement in patient satisfaction scores, there is evidence that bedside handoffs provide patients with the opportunity to better understand their care. After implementation of bedside handoff in an Australian hospital, patients' understanding of their care improved.[12] In an earlier study, we identified a link between understanding of care and frequency of bedside handoffs.[7] Others have reported that patients have a better understanding of their medications after the implementation of bedside handoffs.[13]

Although one of the reported benefits of bedside handoffs is patient participation in care,[6,7,14] nurses' perceptions of patient participation in the process vary significantly from patients' perspectives. In one study,[15] 91% of nurses felt that they encouraged patient participation whereas only 51% of patients felt encouraged to participate. Some studies reported patient involvement in the handoff as low as 5%, whereas others have found it to be more than 50% of patients.[8] While nurses feel that that they encourage and support patient participation, it is the nurses who control the location and discourse of the handoff.[15] Drach-Zahavy and Shilman[16] found that female patients were more likely than male patients to initiate participation and patients who had been previously hospitalized were more likely than first-time patients to participate.

In their interviews with patients, Jeffs et al[17] identified that the bedside handoff allowed for a time during the day when patients could connect with their nurses. This time gave patients a chance to meet the incoming nurse, say goodbye to the off-going nurse, ask questions, provide input, and correct misinformation.[17] Patients in other studies also reported that the bedside handoff gave them an opportunity to correct errors, cross-check expectations, and update nurses.[18,19]

Patient safety in relation to bedside handoffs has been evaluated from 2 perspectives. The first is occurrence of adverse events. Reductions in adverse events such as falls and medication errors have been reported after the implementation of bedside handoffs.[6,13] The use of specific strategies, including face-to-face communication, in bedside handoffs has been linked to a lower

incidence of treatment errors, defined as dosage discrepancies, delays in treatment, and missing documentation.[20]

The second perspective from which patient safety has been examined in the context of bedside handoffs is patients' perceptions of feeling safe.[7,13] Trust in nurses contributes to feelings of safety in patients. Patients' perceptions of satisfaction, understanding, participation, and safety are all reflected in Mollon's[21] concept analysis of trust. The defining attributes of trust include feeling cared for, presence, and knowledge. Trust is built through the development of a therapeutic relationship; this relationship can be built in the space to connect that Jeffs et al[17] describe. Patients feel cared for when nurses are available to patients and are able to respond to their requests for help and assistance. These responses to patients' needs also create a feeling that nurses are attentive to needs and present for the patient. Finally, when nurses provide information and act to meet patient needs competently, patients feel confident in the knowledge that nurses possess.[21,22]

Sustaining change

Although a number of benefits of bedside handoffs have been reported, implementing and sustaining the practice are not without challenges. Changes in routines are disruptive and taxing for nurses. As in any change process, nurse leaders are called upon to support staff nurses throughout the change, hold staff members accountable for practice, communicate best practices and expectations consistently, and monitor performance.[8,14,23-25]

A number of strategies have been employed to support implementation of bedside handoffs and sustain the practice after implementation. These include identifying the need for change, using unit-based champions, and applying principles of continuous process improvement.[6,24,26] We used the Plan Do Check Act (PDCA) framework, incorporating tactics from the literature plus innovative strategies to promote a culture in which bedside handoff is the norm. We labeled this desired normal state a "culture of always."[7]

Aims

The specific aims of this study were to (*a*) validate earlier findings of significant positive correlations between frequency of bedside handoff and patients' satisfaction, understanding of their care, participation in care, and feelings of safety; (*b*) evaluate the effectiveness of strategies to promote sustainability of the implementation of bedside handoff; and (*c*) assess the effect of bedside handoffs on patients' reported trust in their nurses.

METHODS

Setting

The survey was conducted on 5 inpatient adult medical-surgical units at a hospital in the Midwestern United States. The units ranged in size from 26 to 46 beds; proportional sampling was used to reduce the risk of overrepresentation from smaller units in the sample. Nurses on all units worked 12-hour shifts; handoffs occurred at 0700 and 1900. At the time of this study, the nurses' experience with bedside handoffs ranged from 3.5 to 7 years. Approval for the study was given by both hospital and university institutional review boards.

Sample

A convenience sample of prospective patients was identified at the time that a trained research assistant visited the unit. Before approaching any patient, the research assistant consulted the registered nurse (RN) to determine whether the patient met the inclusion criteria for the study. These criteria included age 18 years or more, fluency in written and spoken English, present on the unit for at least 3 handoffs, on that unit for the entire length of stay (LOS), and met the hospital's criteria for giving informed consent. Specific exclusion criteria were a diagnosis of dementia or confusion, isolation precautions, health care professionals, and employees of the health system. A total of 103 patients were surveyed over the course of 7 months. Patients were surveyed on day 2 or later of hospitalization. It was

assumed that patients would have experienced 3 handoffs during that time period.

Actions to enhance sustainability

After the dissemination of the results of the initial study,[7] the nurse leaders implemented an action plan in the 5 units to increase patients' exposure to bedside handoff and to sustain the practice. They communicated long- and short-term measures of success to staff nurses. Staff nurse orientation and reeducation on the handoff practice were enhanced with reference cards and role-playing. Three methods of concurrent monitoring were used. The first was a series of "flash mob" style observations. The second was the implementation of a mystery shopper observation program. Finally, nurse leaders interviewed current patients about their exposure to bedside handoff.

A flash mob is "a large group of people organized by means of the Internet, or mobile phones or other wireless devices, who assemble in public to perform a prearranged action together and then quickly disperse."[27] During the Check and Act phases of the PDCA process, the nursing director would organize as many as 8 nursing leaders from multiple departments to form a flash mob. This group arrived unannounced on the specified unit at shift change for direct observation of bedside handoff and "just in time" coaching.

Businesses such as retail stores, restaurants, hotels, and other establishments often use mystery shoppers to gather information on the customer service provided by the company.[28] To evaluate where handoffs were taking place, student interns were recruited to serve as mystery shoppers. The nursing staff members were led to believe that the nurse manager was not in the building. Dressed in casual attire, so as to appear that they were visiting a patient, the shoppers would walk through the halls of nursing units at shift change to observe where handoffs were being held. The mystery shoppers reported their observations to the director of the nursing unit. The nurse leader offered praise and/or provided remedial coaching to staff members based on the observations.

In addition to concurrent monitoring, the leadership distributed 2 newsletters. These publications discussed patient situations in which bedside handoff had contributed to error prevention and improved care. The newsletter also presented positive quotes from nurses, patients, and families about the process.

Instrument

Patients were asked to respond to demographic items (eg, age, education, gender), whether they had been previously exposed to bedside handoff practices, and the frequency with which they experienced bedside handoff during the current hospitalization. The survey instrument was modified from one used in an earlier study.[7] The 11 items on the original survey were designed to capture information on 4 variables (understanding, safety, participation, and satisfaction). Patients were asked to evaluate the degree to which (*a*) they received information that helped them understand their care, (*b*) bedside handoff helped them feel safe from errors, and (*c*) they agreed with how information was passed on. They also were asked how often they clarified mistakes or misinformation. To capture patients' participation in the handoff, patients were asked how often nurses asked their opinions, and how often they offered opinions during the handoff. As trust in nurses has been identified as a contributor to feeling safe,[17] 4 items were added to the previous survey to capture the degree of trust that patients placed in nurses. These items were adapted from the Trust in Nurses Scale.[29]

Participants were asked to indicate their level of agreement with items on a 4-point Likert scale, ranging from 1 (strongly disagree) to 4 (strongly agree). For the items that asked patients to report their degree of participation in the bedside handoff, the scale ranged from 0 (does not apply or I did not have a need) to 4 (always). The entire survey was reviewed by nurse experts, and the resulting content validity index was found to be 0.82. The

Cronbach α for the instrument was calculated to be 0.79.

Data analysis

Descriptive statistical procedures were used to summarize the sample. The Pearson correlation was used to ascertain whether a statistically significant relationship existed between the reported frequency of bedside handoff and the study variables. Analysis of variance (ANOVA) and post hoc analysis were used to determine whether the means of the responses differed by the reported frequency of handoff. All data analyses were conducted using IBM's SPSS, version 20 (Armonk, New York), for Windows.

RESULTS

Demographic characteristics

The sample was nearly evenly divided between male and female respondents (51% male, 49% female), whereas 86% of the sample identified themselves as Caucasian/white. The mean age of the respondents was 61.5 years, and 89.4% were high school graduates or higher. Just over one-half (51.9%) had at least some college education.

Survey responses

More than half of the respondents (57.7%) reported that they had experienced bedside handoffs prior to the current hospitalization. For the current hospitalization, 81 respondents (77.9%) reported that the RNs "always" conducted bedside handoffs, 19 (18.3%) responded that the RNs conducted bedside handoffs "most of the time," and 3 (2.9%) reported that bedside handoffs were "rarely" done. No respondents stated that they "never" experienced bedside handoff. For the analyses, the sample was divided into 3 groups, defined by reported frequency.

Survey participants were largely positive about the process of bedside handoffs, especially when they reported that they "always" experienced it. Mean scores for this group (N = 81) ranged from 3.30 (SD = 0.749) to 3.83 (SD = 0.380). For the group of participants who experienced bedside handoffs "most of the time" (N = 19), the mean scores ranged from 2.78 (SD = 0.548) to 3.74 (SD = 0.452). Those who reported that they "rarely" experienced bedside handoffs (N = 3) had mean scores ranging from 1.33 (SD = 1.528) to 3.5 (SD = 0.707).

Pearson correlations revealed significant positive correlations when patients reported that they "always" experienced bedside report (r = 0.198-0.497; $P \leq$ .001-.047) for items about understanding, safety, participation, and satisfaction. For those patients who "rarely" experienced bedside handoff, correlations for the same items were significantly negative, with r values ranging from −0.433 to −0.198 ($P <$ .001-.044). Only 2 items showed significant correlations for patients who experienced bedside report "most of the time," and those correlations were negative. Results of the correlations are displayed in the Table.

Two of the 4 items on the instrument that were adapted from the Trust in Nurses Scale[29] showed significant correlations with the frequency of bedside handoff. When patients "always" experienced bedside handoff, there was a significant positive correlation with the perception that nurses were providing accurate information about patients' conditions ($r = 0.444$; $P <$ .001) and that RNs did what they said they would do ($r = 0.261$; $P = .008$). The remaining items were not significant.

A between-groups ANOVA was conducted to examine means. The 3 groups were labeled Always, Most of the Time, and Rarely. There were statistically significant differences between groups for 8 of the 13 items on the survey. Post hoc analysis with Tukey HSD revealed that the group means for the Always group were significantly higher than those for the Rarely group for 8 of the 13 items (61%). The means of the Always group were also significantly higher than those of the Most of the Time group on 4 of those 8 items, and for 2 of those 4, the means of the Most of the Time group were significantly higher than those of the Rarely group. The post hoc analysis

Table. Correlations of Survey Items With Reported Frequency of Bedside Handoff

	Reported Frequency of Bedside Handoff								
	Always			Mostly			Rarely		
	M	*r*[a]	*P*	*M*	*r*[a]	*P*	*M*	*r*[a]	*P*
Survey items[b]									
RNs asked me my opinions, concerns, and questions.	3.30	0.261	.008	2.89	−0.190	.055	2.33	−0.198	.044
I understood the information shared by RNs.	3.40	0.285	.004	3.16	−0.129	.196	2.00	−0.396	.000
Received information during that helped me understand my care.	3.36	0.245	.012	3.11	−0.140	.158	2.33	−0.275	.005
During bedside report RNs planned ahead to meet my future needs.	3.49	0.497	.000	2.78	−0.405	.000	2.33	−0.275	.005
Bedside report allowed me to be involved in my care.	3.38	0.198	.047	3.16	−0.109	.277	2.00	−0.271	.006
Bedside report helped me feel safe from medical errors or mistakes.	3.46	0.317	.001	3.05	−0.224	.025	2.00	−0.295	.003
Helped decrease my fears, anxiety, and apprehension.[c]	3.04	0.021	.907	3.17	0.084	.626	2.00	0.241	.185
Satisfied with how information was passed on during bedside report.	3.58	0.208	.035	3.47	−0.032	.747	2.00	−0.433	.000
Participation items[d]									
I offered my opinions, concerns, and questions during bedside report.	3.05	0.049	.626	3.12	−0.002	.985	2.00	−0.115	.252
How often did you clarify misinformation	2.41	−0.043	.675	2.46	0.53	.605	3.00	−0.022	.830
Items from the Trust in Nurses Scale (Radwin and Cabral, 2009)									
How often did you feel the RNs were acting in your best interest?	3.83	0.115	.250	3.74	−0.081	.419	3.50	−0.108	.279
How often did you trust what the RNs told you?	3.78	0.061	.546	3.74	−0.031	.754	3.50	−0.088	.378
How often did the RN provide accurate information?	3.69	0.444	.000	2.84	−0.305	.002	1.33	−0.379	.000
How often did the RNs do what they said they would do?	3.60	0.261	.008	3.37	−0.088	.376	1.67	−0.433	.000

[a]Pearson correlation (2-tailed).
[b]Scale from 1 = strongly disagree to 4 = strongly agree. Scores based on the number of answers provided.
[c]Represents only those subjects who answered "yes" to "Did you have any fear, anxiety, or apprehension during your stay?"
[d]Scale from 0 = no need to or does not apply to 4 = always.

confirmed the result of the ANOVA, showing that there were no significant differences between group means for 5 of the items.

Quality improvement measures

All 5 units successfully met the short-term process measures when 100% of RNs completed quizzes and case scenarios within 6 months; 100% of RNs were observed for competency via flash mob twice within a 6-month period; and 95% of patients reported experiencing bedside handoff when asked by nurse leaders during daily rounds. Two of the 5 long-term measures were achieved when the units' monthly quality score derived from an audit tool reached 95% and 100% of RNs demonstrated competency in practice annually. Three of the 5 units achieved 100% on each mystery shopper observation; however, the overall average was 93%, which did not meet the target of 95%. The fourth measure was achievement of a 90th percentile score on the HCAHPS nursing communication items. While an increase was noted, collectively, the 5 departments were unable to sustain a 90th percentile ranking for "nurse courtesy and respect," "nurses listened," and "nurses explained." The final goal, to have 90% of patients report a frequency of "always" having experienced bedside handoff in study replication, was not met. There was a 13% increase (from 63% to 76%) in reporting "always" experiencing bedside handoff on those units that participated in both studies. This result approached statistical significance ($t = 1.94$, $df = 149$; $P = .054$). The proportion of patients overall who experienced bedside handoffs with any frequency increased from 94% to 100%.

DISCUSSION

The findings of this study validate earlier findings of significant correlations between "always" receiving bedside handoff and patient satisfaction, understanding, safety, and participation in care. By examining the mean responses of patients, we were able to verify that patients who "always" received bedside handoffs reported significantly higher levels of agreement with most of the items on the survey. Therefore, these findings are uniquely positioned within the literature, as this is only the second study to call attention to the effect that frequency of bedside handoff has on patients' perceptions.[7,8]

For most items, the mean responses of patients were significantly higher for patients in the Always group than for those in the Most of the Time group. However, means for the Most of the Time group were not significantly different from those in the Rarely group. This underscores our earlier position that the benefits of bedside handoffs are realized only when patients experience them consistently.

We also identified findings consistent with those of other researchers about the practice of bedside handoffs.[8,14-16] When patients "always" experienced bedside handoff, there was a positive correlation with their perception of being involved in their care, and patients perceived that nurses asked for their opinions. Although there was a significant correlation between "always" and being asked for opinions, there was no significant difference between the means for the frequency groups. From this, we conclude that patients are being asked for contributions during the bedside handoff no matter how frequently it is used.

Patients were less likely to perceive that RNs were planning for their care when bedside handoff occurred only "most of the time." This is a change from our previous study,[7] in which there was no significant correlation for the Most of the Time group, and even patients who were in the Rarely group were able to identify that RNs were planning for patients' care. This finding may be a reflection of the content of the handoff and not related to how often the bedside handoff occurs.

It also appears that patients feel they are less safe when bedside handoff does not "always" occur, and they perceive that there are more inaccuracies in the information being passed on when bedside handoff occurs less than "always." These feelings may result from uncertainty as to whether the bedside handoff will take place. They also may be

a consequence of lack of visibility of planning and vigilance; when patients "always" experienced bedside handoff, they knew what to expect and when to expect it. Uncertainty about the practice of bedside handoffs appears to contribute to uncertainty about plans and unease about safety and the nurses' accuracy about patients. These findings were validated by the post hoc analysis, which showed significant differences in the mean responses by frequency of bedside handoff.

The significant positive correlations between the perception that nurses were providing accurate information and that the RNs did what they said they would do likely result from the actual exposure to the nurses' discussions at the bedside. This does not necessarily indicate that patients who did not "always" experience bedside handoff thought nurses were inaccurate or failed to follow through. Rather, it may mean that patients were unable to evaluate these items from the Trust in Nurses Scale[29] because they did not hear the information that was passed on or the planning that occurred. Patients were not asked directly to state the degree to which they trusted nurses, but it appears that there is no link between the performance of bedside handoff and patients' trust in their nurses.

All of the significant correlations found in the Rarely group were negative. These results demonstrate that as the frequency of bedside handoff decreased, there was less agreement with the survey items. The less frequently that bedside report was conducted, the more patients disagreed that they were satisfied, that they understood their care, that they participated in their care, and that they felt safe.

There were no significant correlations for the 2 items asking patients to indicate their level of participation in the handoff. As found in earlier studies,[15,16,19] patients opted not to provide input even when they felt invited to do so.

Limitations

Our recruiting methods and characteristics of the sample may limit the generalizability of our findings. The convenience sample for this study was relatively small and homogeneous. Patients who agreed to participate were largely self-selected. As such, the sample may have included patients who were more engaged in their care than a random sample might have yielded. In addition, there was no control for LOS; inclusion criteria only specified that patients were hospitalized for at least 2 days. Longer LOS may have influenced patients' perceptions of the handoff process and/or their understanding of their care.

The sample was exclusively from medical-surgical units, and the patients were cognitively intact. Thus, patients (and their families) who might have experienced a sudden critical illness or injury warranting a higher level of care were excluded from the study. This group of patients and family members might have given different insight into the study topics than our sample did.

The Trust in Nurses Scale was designed to capture patients' feelings of trust in their nurses.[29] We modified questions from that scale to attempt to measure patients' perceptions of trust during bedside handoffs. Our adaptation to measure a specific process of care may have compromised the validity of the scale.

CONCLUSION

Although we did not attain some of the goals that were set, we did realize substantial improvement in the percentage of patients who reported experience with bedside handoffs. That improvement was a result of the use of the PDCA process to improve performance. Specific follow-up actions during the Check and Act phases of the process were especially effective in assessing the diffusion of bedside handoff practices and focusing remedial actions where they were needed. Novel approaches such as mystery shoppers and flash mobs are time consuming but appear to be effective in achieving progress toward goals and in creating and sustaining practice changes.

Our previous study demonstrated significant relationships between frequency of

bedside handoff and patients' perceptions of satisfaction, participation, understanding of care, and safety. This study validated those correlations between frequency and patients' perceptions, and the deeper statistical analysis verified that the responses of patients who always experienced bedside handoff were significantly higher than those patients who experienced it only most of the time or rarely.

There have been a number of changes in nursing leadership within the organization, but the results of this study have been disseminated to encourage maintenance and continued improvement. The findings also are being used to encourage the implementation of bedside handoffs on additional units within the organization, thus furthering the development of a "culture of always" in which providers and patients develop effective partnerships.

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