



Introducing Bedside Handover on a Busy Surgical Ward in Ghana: A Proposed Implementation Framework

Bekzat Nikolic^{1*}, Suresh Ndlovu², Nadia Jarrett³

¹Department of Nursing, Limpopo Institute of Nursing, Germany

²Department of Nursing, Amazon Graduate Institute of Nursing, Bahrain

³Department of Nursing, Loire School of Nursing, Tanzania

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Abstract

Nursing handover at the change of shift is commonly given at the nurses' station, away from the patients it concerns. Moving it to the bedside is promoted as a way to improve the accuracy of information, to let the incoming nurse see each patient at once and to involve patients in their care. Published accounts of how to make the change come largely from well-resourced hospitals with small bays. This article proposes a six-phase framework for introducing bedside handover on a high-occupancy surgical ward in Ghana, where wards are typically open, relatives are often present, several languages are spoken and nurses care for many patients each. The phases are: agree the aim and form a ward team; map current handover; co-design a two-part protocol with a short safety briefing at the station and a structured exchange at each bedside; prepare nurses and patients; test on a few beds with plan-do-study-act cycles; and spread and sustain. The framework draws on bedside handover research, the Model for Improvement, the Consolidated Framework for Implementation Research and Ghanaian policy on quality, patient rights and data protection. It is a proposal and has not been applied or evaluated here. Measures by which a ward could judge it are suggested, and its limits are stated.

Keywords: *Bedside handover, Nursing handover, Surgical nursing, Quality improvement, Implementation, Ghana*

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1. Introduction

Each change of shift transfers responsibility for every patient on a ward from one group of nurses to another, and the quality of the information passed across determines what the incoming nurses know when they begin. The World Health Organization named communication during handover among its first set of patient safety solutions and recommended a standardised approach, enough time, and the involvement of patients and families (World Health Organization, 2007). On a surgical ward the stakes are plain: who returned from theatre in the last hours, who has a drain or an infusion, who is to be kept fasting, whose pain or bleeding needs watching.

* Corresponding author: Bekzat Nikolic, Department of Nursing, Limpopo Institute of Nursing, Germany. E-mail: bekzat.nikolic@limpopo.edu

Bedside handover moves this exchange from the office or station to the patient's side. Outgoing and incoming nurses walk the ward together, the incoming nurse sees the patient, the lines and the charts while hearing about them, and the patient can listen, correct and ask. The practice has been described most fully in Australian hospitals, where case study research documented its structure, its processes and the views of staff (Chaboyer *et al.*, 2010) and identified the change management strategies that helped it take hold (McMurray *et al.*, 2010).

Ghana's national quality strategy commits the health sector to safer, more person-centred care (Ministry of Health, 2016), and bedside handover is consistent with that aim. The setting, however, differs from the one in which the practice was developed. This article proposes a framework for introducing bedside handover on a busy surgical ward in a Ghanaian hospital. It is a method paper. It describes no particular ward, reports no results, and the framework has not been applied or tested in the work presented here.

2. Background

Two questions need answering before a framework is designed: how strong the evidence for bedside handover is, and what in the Ghanaian ward setting bears on how it should be done.

2.1. What is known about bedside handover

The evidence is encouraging and limited. A Cochrane review that sought randomised trials comparing styles of nursing handover found none that met its criteria (Smeulders *et al.*, 2014). A review of studies of bedside shift-to-shift handoff reported improvements in patient and nurse satisfaction and some safety indicators, in designs that were mostly before-and-after comparisons on single units (Mardis *et al.*, 2016). Stronger evidence exists for structured handover in general: a multicentre study of a handoff programme for resident physicians found a reduction in medical errors and preventable adverse events after its introduction (Starmer *et al.*, 2014). The structured format most widely used in nursing is SBAR (situation, background, assessment, recommendation), brought into health care as a shared mental model for communication between clinicians (Haig *et al.*, 2006).

Patient involvement is the feature that sets bedside handover apart, and the research on it is nuanced. A mixed-methods review found that many patients value being included while preferences vary, and that both patients and nurses worry about sensitive information being overheard (Tobiano *et al.*, 2018). Bedside handover was introduced in several of the early Australian sites as a quality improvement initiative and not as a research intervention, which is how most wards will meet it (Chaboyer *et al.*, 2009).

2.2. Features of the setting

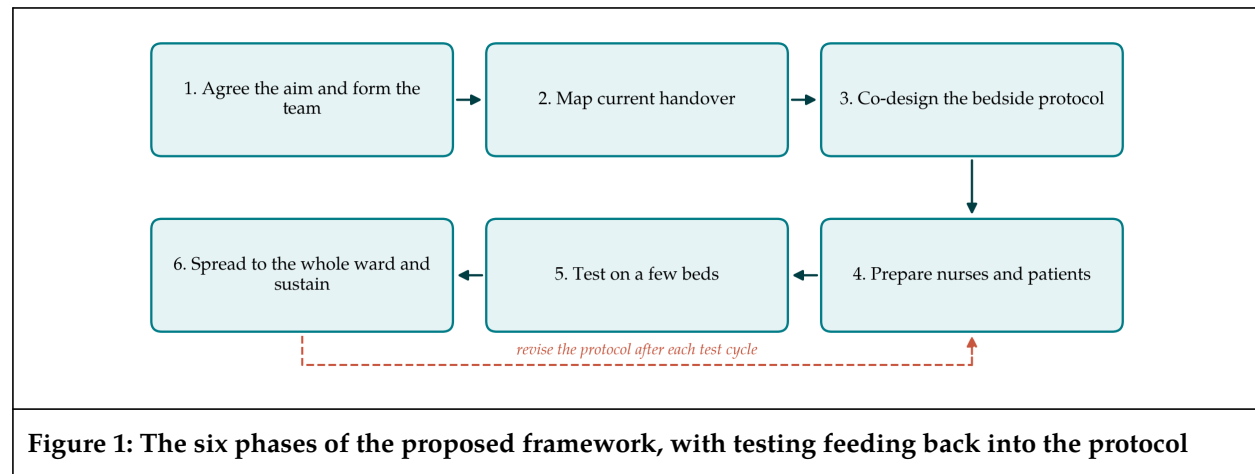
Several features of a busy surgical ward in a Ghanaian public hospital shape the design. Wards are commonly open, with beds close together and curtains or screens the only partition, so that anything said at one bedside may be heard at the next. Relatives are often at the bedside and take part in care. English is the official language and the language of records, while patients may be most at ease in Akan, Ewe, Ga, Dagbani or another Ghanaian language. Nurses are responsible for many patients each; the global shortage of nurses is concentrated in low- and middle-income countries, those of the African region prominent among them (World Health Organization, 2020). Handover is traditionally led by the senior nurse of the outgoing shift, and hierarchy within the team is marked.

The legal and policy setting matters too. The Patient's Charter of the Ghana Health Service sets out the patient's rights to information about their condition and to privacy and confidentiality (Ghana Health Service, 2002), and the Data Protection Act treats information about a person's health as special personal data (Republic of Ghana, 2012). Bedside handover serves the first of those rights and can endanger the second. A framework for Ghana has to treat confidentiality as a design problem from the start.

3. The Proposed Framework

The framework has six phases, shown in sequence in Figure 1. It combines the Model for Improvement,

which asks what a team is trying to accomplish, how it will know that a change is an improvement and what changes it can make, and then tests those changes in plan-do-study-act cycles (Langley *et al.*, 2009), with attention to the determinants of implementation catalogued in the Consolidated Framework for Implementation Research (Damschroder *et al.*, 2009). Table 1 summarises the activities and outputs of each phase.



3.1. Phase 1: Agree the aim and form the team

The first phase establishes why the ward wants to change and who will lead. Kotter (1996) argues that change efforts fail when urgency is not established and no guiding coalition is formed, and the Australian experience bears this out (McMurray *et al.*, 2010). The ward manager, two or three respected staff nurses from different shifts, a night nurse and a representative of the surgical team form a small group, with the backing of nursing administration. They write an aim that is specific and modest, for example that within a stated period every morning handover will include a bedside exchange for every patient.

3.2. Phase 2: Map current handover

Before designing anything, the team describes what happens now. Members observe several handovers on each shift and note where they take place, how long they last, what is said for each patient, what is written, how often they are interrupted and what the incoming nurses go on to discover for themselves. Staff are asked what works. The purpose is to identify the information a surgical nurse needs and the constraints, such as the time at which the night staff's transport leaves, that any new routine must respect.

Table 1: Phases of the proposed framework with their main activities and outputs

Phase	Main activities	Output
1. Aim and team	Secure support of ward manager and nursing administration; form a small ward group	Written aim and named team
2. Map current practice	Observe handovers on all shifts; ask staff what works and what is missed	Description of present handover
3. Co-design the protocol	Agree station briefing, bedside script, safety checks and rules on sensitive information	One-page protocol and prompt card
4. Prepare people	Short practice sessions for nurses; explanation for patients and relatives	Trained staff; patient information
5. Test on a few beds	Run plan-do-study-act cycles on one shift and one bay; adjust	Revised protocol; early measures
6. Spread and sustain	Extend to all beds and shifts; audit; include in orientation	Routine practice with periodic audit

3.3. Phase 3: Co-design the protocol

The protocol should be written by the nurses who will use it. A two-part structure is proposed. The first part is a brief safety briefing at the station for the whole incoming shift, covering the ward state, patients causing concern, staffing and anything too sensitive for an open ward. The second is the bedside exchange, patient by patient, following a fixed order such as SBAR. At each bed the outgoing nurse introduces the incoming nurse, gives the reason for admission, the operation and the day since it, the current condition and the plan, and both look at the patient, the wound site, drains, infusions and charts together. The patient is asked whether anything has been missed.

Three design decisions are specific to the setting. The first concerns sensitive information. The team agrees a list of matters that are never spoken aloud at the bedside, such as a new diagnosis the patient has not yet been told, HIV status and social circumstances, and these are passed on at the station or in writing. The second concerns relatives: the patient is asked, before handover begins, whether those present may stay. The third is language. The clinical exchange between nurses may be in English, and the summary and the question to the patient are given in a language the patient understands. On a ward with many beds, time is the binding constraint, and the script should be short enough that the round fits within the overlap between shifts.

3.4. Phase 4: Prepare nurses and patients

Nurses in published studies have feared that bedside handover takes longer, that they will be exposed in front of patients and that confidentiality will suffer (Tobiano et al., 2018). Preparation should address these concerns directly. Short practice sessions on the ward, in which pairs rehearse the script at an empty bed, are more useful than a lecture. Junior nurses practise presenting in front of seniors, and seniors practise inviting questions. Patients and relatives are told on admission, in plain terms and in their own language, that nurses will come to the bedside at the change of shift, why, and that they may decline to have their care discussed there.

3.5. Phase 5: Test on a few beds

The protocol is first tried on one shift change and a handful of beds. After each test the pair involved and the team spend a few minutes on what happened: whether the script was followed, how long each patient took, what the patients said and what was awkward. Changes are made and the next test is slightly larger. This is the plan-do-study-act cycle of the Model for Improvement (Langley et al., 2009), and its merit here is that problems of time, noise and privacy are met on a small scale, where they can be solved before the whole ward is committed.

3.6. Phase 6: Spread and sustain

Once the protocol runs smoothly on some beds and one shift it is extended to all. Sustaining it needs a few simple supports: a prompt card at each bed or on the handover sheet, the ward manager or a deputy joining handover regularly in the first weeks, a brief monthly audit, and inclusion of bedside handover in the orientation of new and rotating staff. Night-to-morning handover, when the outgoing staff are most tired and patients may be asleep, deserves particular attention and may justify a shorter script.

4. Judging Whether the Change Works

A ward that adopts the framework should decide in advance how it will judge the result. The taxonomy of implementation outcomes proposed by Proctor et al. (2011) is a useful guide, since it separates whether a practice is being delivered from whether it benefits patients. Acceptability can be gauged by brief questions to nurses and patients, fidelity by observing a sample of handovers against the protocol, and feasibility by timing them. Outcome measures might include the completeness of the information handed over, checked against the record, and incidents in the first hours of a shift that can be traced to missing information. Run charts of a few such measures, kept by the ward, are within reach of any team. If the work is written up, the SQUIRE guidelines set out what a report of a quality improvement project should contain (Ogrinc et al., 2016).

5. Limitations and What Remains to Be Shown

The framework is a proposal. It has not been implemented or evaluated here, and no claim is made that it will improve handover on any given ward. It is built from studies conducted mainly in high-income countries and from general improvement methods, adapted by reasoning to a setting in which published evaluations of bedside handover are scarce. Whether patients on an open Ghanaian ward welcome the practice, whether it can be completed in the time available when each nurse has many patients, and whether the safeguards proposed for confidentiality are adequate are empirical questions. So is the larger question, unresolved anywhere, of whether bedside handover reduces harm to patients.

The description of the setting is deliberately general. Hospitals in Ghana differ in size, staffing and ward layout, and a teaching hospital in a city is not a district hospital. Teams should treat every element of the framework as provisional and let their own mapping in the second phase override the assumptions made here. Evaluation by those who use it, reported with enough detail of context for others to learn from, would be the most valuable sequel to this article.

6. Conclusion

Bedside handover promises more accurate information and a more involved patient, and its adoption on a crowded, open surgical ward calls for adaptation and not simple transfer. The framework proposed here moves in six phases from an agreed aim to routine practice, puts the design in the hands of ward nurses, separates what may be said at the bedside from what may not, and relies on small tests before wide adoption. It has yet to be tried. Its usefulness will be known when ward teams in Ghana apply it, measure what follows and report what they find.

Conflict of interest

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