Bedside RN-to-RN Safety Checks Decrease Shift Change Patient Safety Alerts by 75%

Reducing Patient Harm By Creating A Culture Of Safety

Author(s)

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Background

Patient safety events happen every day in hospitals. Most of these events occur due to inconsistent communication[1]. The first line of communication is through shift report. Bedside report and safety checklists have been shown to improve patient safety and outcomes by improving communication and increasing visualization of the patient and their environment[2,3].

Purpose

The purpose of this project was to re-institute RN-to-RN bedside safety checks at shift change to decrease the number of patient safety alerts (PSAs), increase patient safety, and promote a culture of safety.

Methods

This was a quality and practice improvement project that occurred on the Intermediate Care Unit (IMCU) over 3 months and was quickly adopted by the Adult Health/Critical Care collaboratives. A bedside safety checklist was created and filled out by both RNs at change of shift, indicating which safety items were visually checked. The form was later incorporated into an Epic Flowsheet. Compliance was audited weekly by management with a goal of 100%. PSA data was also collected throughout this project.

IMCU Bedside Safety Checklist	Date:		Date:		Date:		Date:	
	700	1900	700	1900	700	1900	700	1900
Introduce oncoming shift								
Update whiteboard								
Bed alarm on								
Call light in reach								
Suction present and working								
IV site assessment								
Lines/Drains assessed								
DNR/DNI is on armband								
Carotid incision/Groin/TR band site								
Skin Checked under BIPAP/CPAP								
Day RN Initials	x	x	x	x	x	x	x	x
Night RN Initials	x	x	x	x	x	x	x	x

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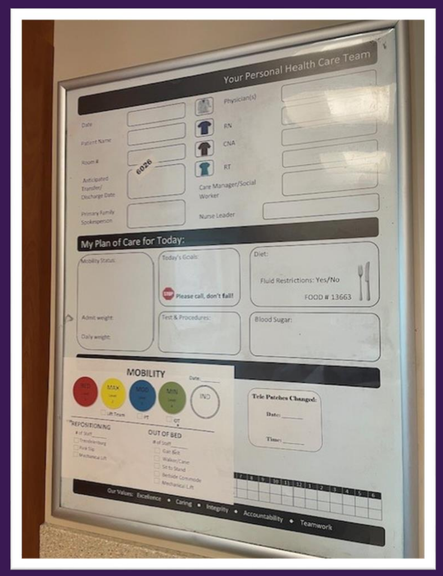
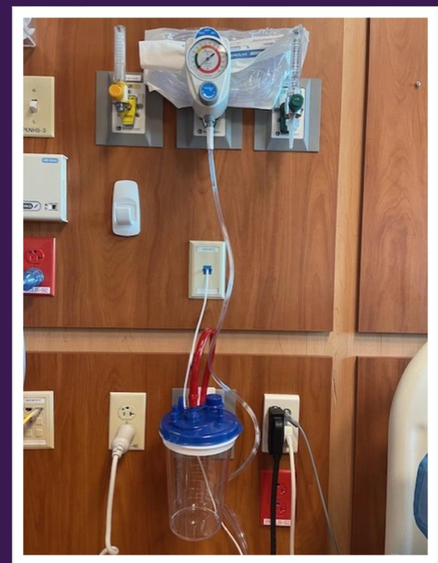
Day RN Initials	x	x	x	x	x	x	x	x
Night RN Initials	x	x	x	x	x	x	x	x





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Results

At the start of this project, an average of 4 PSA's were filed monthly regarding safety issues that were found after change of shift. At the conclusion of the project, only 1 PSA was submitted resulting in a 75% decrease in patient harms related to IV infiltrations, falls, improper ID band identification, and emergency equipment.

Conclusions

A standardized safety check improves patient outcomes and decreases adverse events at shift change. Positive RN feedback and peer accountability during safety checks reinforced a culture of safety

Implications for Clinical Practice

RN-to-RN bedside safety checks were adopted hospital wide with the support of the Evidence Based Practice Council, and the Adult Health and Critical Care Collaboratives. Modified patient safety checks at shift change are recommended for any clinical unit, thus reinforcing a culture of safety.

Acknowledgements

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