

Original Article

Nursing management strategies for optimizing SBAR-based bedside handover implementation in an inpatient unit

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Abstract

Background: Bedside handover is a clinical communication strategy that supports continuity of care, patient safety, and patient involvement. The initial assessment in the inpatient unit showed an implementation rate of 68%, nurse-patient interaction during handover of only 33%, non-standardized documentation, and the absence of an SBAR-based bedside handover SOP that consistently involved patients.

Objective: This article aimed to evaluate nursing management strategies for optimizing SBAR-based bedside handover implementation in an inpatient unit at a hospital in Jakarta.

Methods: This quality improvement study used a pre-post evaluation approach and involved 20 inpatient nurses, including 13 diploma-prepared nurses and 7 professional nurses. The initial assessment included observation, brief interviews, document review, and one FGD with unit nurses. The intervention was implemented through baseline assessment, development of an SBAR-based SOP and documentation format, socialization, training and simulation, appointment of handover champions, supervision, and three monthly audit cycles from August to October 2025. Data were analyzed descriptively.

Results: Bedside handover implementation increased from 68% in August to 77% in September and 90% in October. At baseline, patient interaction during handover was 33%, form uniformity was 82%, 50% of nurses reported documentation difficulties, and leadership during handover was documented in 27% of observations. The background and assessment components improved but remained inconsistently communicated.

Conclusion: Nursing management strategies involving procedure standardization, training, documentation, handover champions, supervision, and continuous audit contributed to improved SBAR-based bedside handover. Further strengthening of background, assessment, and patient involvement is required to ensure that improved compliance is accompanied by better clinical communication quality.

Background

Nursing leaders play a strategic role in ensuring quality of care and patient safety in hospitals. Nursing management functions include planning, organizing, actuating, and controlling, which must be integrated to sustain changes in clinical practice (Nursalam, 2014; Marquis & Huston, 2010). These functions are particularly important in inpatient care because nurses work in shifts and depend on the continuity of clinical information across healthcare professionals.

Patient safety is strongly influenced by the effectiveness of clinical communication. Communication failures during handover can result in the loss of critical information, duplication of care, delayed interventions, and an increased risk of patient safety incidents. Bedside handover is a recommended approach because the transfer of information occurs near the patient, allows immediate clarification, and enables patients and families to participate in validating

clinical information (Chien et al., 2022; Ghosh et al., 2025).

Structured communication such as SBAR (Situation, Background, Assessment, Recommendation) can help nurses convey information concisely, systematically, and with a focus on patient safety. Studies have shown that SBAR can improve the quality of handover communication, reduce information errors, and strengthen clinical teamwork (Pazar et al., 2024; Kosim & Saimi, 2025; Nurti et al., 2025). However, successful SBAR implementation depends not only on the availability of a format but also on nurses' competence, supervision, safety culture, and organizational support.

A baseline assessment at a hospital in Jakarta identified a clear practice gap. The initial audit score was only 68%, nurse-patient interaction during handover was 33%, leadership or direction during handover was observed in only 27% of cases, and 50% of nurses reported difficulties documenting handover reports. Although form

standardization had reached 82%, the unit did not have an SBAR-based bedside handover SOP that explicitly regulated patient involvement, information validation, documentation, and follow-up. These findings indicated that handover practice remained focused on information exchange among staff and did not yet fully support structured communication and patient-centered care. Fishbone and SWOT analyses showed that the problem was multidimensional and involved human resources, methods, materials, the environment, finances, and organizational systems. Therefore, this article aimed to evaluate nursing management strategies for optimizing the implementation of SBAR-based bedside handover in an inpatient unit.

Methods

Study Design

This study employed a quality improvement design with a pre-post evaluation approach to assess the implementation of SBAR-based bedside handover. The project was conducted in an inpatient unit of a private hospital in Jakarta from July to October 2025. The improvement strategies included procedure standardization, staff training, simulation, appointment of bedside handover champions, supervision, mentoring, feedback, and monthly audits.

Sampling

The study used total sampling by involving all 20 nurses working in the inpatient unit. The participants consisted of 13 Diploma III-prepared nurses (65%) and seven professional nurses with a Ners qualification (35%). All nurses participated in the initial assessment, socialization, training, supervision, and evaluation of SBAR-based bedside handover implementation.

Instruments

Data were collected using an observation checklist, a brief interview guide, a document review form, and a focus group discussion guide. A fishbone diagram was used to identify the root causes of suboptimal bedside handover implementation, while a SWOT analysis was used to examine internal strengths and weaknesses as well as external opportunities and threats. An SBAR-based bedside handover audit checklist was subsequently developed to assess compliance with handover components, including introduction, patient identification, situation,

background, assessment, recommendation, patient involvement, documentation, and closing.

Data Collection

The baseline assessment was conducted in July 2025 through direct observation of intershift handovers, brief interviews with nurses, document review, and one focus group discussion involving nurses from the inpatient unit. The initial assessment identified an overall implementation rate of 68%, patient interaction during handover of 33%, leadership during handover of 27%, form uniformity of 82%, and documentation difficulties reported by 50% of nurses.

The intervention was implemented sequentially. First, the project team identified priority problems based on the baseline assessment, fishbone analysis, and SWOT analysis. Second, the nursing team developed and approved an SBAR-based bedside handover standard operating procedure, a standardized documentation format, and an audit checklist. Third, the procedure was introduced to all nurses, and bedside handover champions were appointed. Fourth, SBAR communication training, case simulation, and guided practice were conducted in August 2025. Fifth, supervision, mentoring, and direct feedback were provided during September and October 2025. Finally, three audit cycles were conducted in August, September, and October 2025 to evaluate changes in implementation.

Data Analysis

The data were analyzed descriptively. Compliance with bedside handover implementation was calculated as the percentage of completed items on the audit checklist. The results of the three audit cycles were compared to identify changes over time. Qualitative information obtained from observations, interviews, the focus group discussion, and document review was summarized to describe implementation barriers, improvement processes, and components requiring further strengthening. The overall implementation rate increased from 68% in August to 77% in September and 90% in October 2025.

Ethical Consideration

This quality improvement project was conducted after obtaining permission from the hospital and

the inpatient unit management. The nurses were informed about the purpose and procedures of the project before participating in interviews, discussions, training, and evaluation activities. Participation was voluntary, and the confidentiality of participants' identities and

Results

The baseline assessment showed that bedside handover implementation was suboptimal. The unit employed 20 nurses, including 13 diploma-prepared nurses and 7 professional nurses (Ners). The initial audit score was 68%. Observations showed that patient interaction during handover was only 33%, leadership or direction during

responses was maintained throughout data collection and reporting. No individual nurse or patient identity was presented in the study findings. The name of the ethics committee and ethical approval number should be added if formal ethical approval was obtained..

handover was 27%, and form standardization was 82%. Interviews and the FGD indicated that 50% of nurses experienced documentation difficulties, understanding of bedside handover varied among nurses, and no SBAR-based SOP consistently regulating patient involvement was available. A summary of the baseline findings is presented in Table 1.

Table 1. Summary of Baseline Observation, Interview, FGD, and Document Review Findings

Source/ Aspect	Main Finding	Supporting Data	Implication for Improvement
Staff profile	The educational composition was dominated by Diploma III nurses	13 Diploma III nurses (65%); 7 professional nurses (Ners) (35%)	Training should include simulation and supervised practice
Handover observation	Patient involvement and process leadership were inconsistent	Patient interaction 33%; handover leadership 27%	The SOP should include an opening, patient validation, and the role of the handover leader
Interviews and FGD	Nurses experienced documentation barriers and did not have a consistent understanding	Documentation difficulties were reported by 50% of nurses	A concise format, SBAR training, and coaching are required
Form review	Forms were relatively uniform but were not fully SBAR-based and remained paper-based	Form standardization 82%	The format should be standardized and integrated into the documentation workflow
Policy review	No SBAR-based bedside handover SOP explicitly involved patients	A specific SOP was not available at baseline	Developing and approving the SOP became a priority

The SWOT analysis showed that the hospital had several strengths, including existing nursing SOPs, a digital service system, hospital accreditation, relatively straightforward internal coordination, experienced nursing staff, and an available clinical nurse educator. The main weaknesses were inadequate supervision, mentorship, and coaching; inconsistent implementation of nursing care standards and quality indicators; and suboptimal SBAR-based handover. Opportunities

included support from hospital and Ministry of Health policies, continuing education and training programs, e-learning, benchmarking, and nursing career development. Threats included accreditation demands, service competition, increasing patient complaints, potential turnover among younger nurses, intergenerational competency gaps, limited training budgets, and dependence on senior staff.

Table 2. Summary of the SWOT Analysis of Bedside Handover Implementation at Hospital X

Source/ Aspect	Main Finding	Supporting Data	Implication for Improvement
Staff profile	The educational composition was dominated by Diploma III nurses	13 Diploma III nurses (65%); 7 professional nurses (Ners) (35%)	Training should include simulation and supervised practice
Handover observation	Patient involvement and process leadership were inconsistent	Patient interaction 33%; handover leadership 27%	The SOP should include an opening, patient validation, and the role of the handover leader
Interviews and FGD	Nurses experienced documentation barriers and did not have a consistent understanding	Documentation difficulties were reported by 50% of nurses	A concise format, SBAR training, and coaching are required
Form review	Forms were relatively uniform but were not fully SBAR-based and remained paper-based	Form standardization 82%	The format should be standardized and integrated into the documentation workflow
Policy review	No SBAR-based bedside handover SOP explicitly involved patients	A specific SOP was not available at baseline	Developing and approving the SOP became a priority

Evaluation was conducted through three unit audit cycles in August, September, and October 2025. Performance increased from 68% in the initial August audit to 77% in September after dissemination and training, and then reached 90% in October after supervision, mentoring, and feedback were strengthened. The most notable improvements occurred in the consistency of the opening, patient identification, communication of Situation and Recommendation, use of the

documentation format, and handover closure. However, Background did not always include relevant clinical history and therapy, while Assessment did not always summarize changes in condition, nursing problems, and patient risks. Patient involvement also increased, but post-intervention percentages for individual components were not recorded separately. Details of the audit components and available data are presented in Table 3.

Table 3. Bedside Handover Audit Results by Assessment Component

Component	August 2025	September 2025	October 2025	Detailed Findings
Opening/ introduction	Inconsistent	Becoming more consistent	Consistent	The opening and explanation of the purpose of handover improved after SOP implementation and supervision
Patient identification	Not always complete	Improved	Mostly consistent	Use of patient identifiers and direct confirmation became more structured
Situation	Generally communicated	More concise and focused	Consistent	The patient's current condition and main problems became clearer
Background	Incomplete	Improved but still variable	Further strengthening required	Clinical history, therapies, and relevant information were not always communicated completely
Assessment	Incomplete	Improved but still variable	Further strengthening required	Changes in condition, nursing problems, and patient risks were not always summarized

Component	August 2025	September 2025	October 2025	Detailed Findings
Recommendation	Not always explicit	Clearer	Mostly consistent	Follow-up plans and monitoring priorities became more focused
Patient validation/ involvement	Patient interaction 33%	Increased; not recorded separately	Increased; not recorded separately	Patients were increasingly invited to confirm concerns and the care plan
Documentation	Form standardization 82%; difficulties 50%	SBAR format introduced	More consistent	The standardized format reduced variation, but digital integration remained necessary
Closure	Inconsistent	Improved	Consistent	Summarization and confirmation of the receiving nurse's responsibilities became clearer
Overall performance	68%	77%	90%	Three audit cycles showed a gradual increase in compliance

Discussion

The main findings indicate that nursing management strategies contributed to improved SBAR-based bedside handover implementation. The increase from 68% to 90% across three audit cycles demonstrated improved compliance following procedure standardization, SBAR training and simulation, use of a standardized documentation format, appointment of handover champions, and regular supervision. The gradual improvement from August to September and October also showed that practice change requires repeated reinforcement and cannot be achieved through a single dissemination session.

The implementation of an SOP and a standardized documentation format provided a mechanism for ensuring greater consistency in the information communicated during handover. Standardization is important in clinical practice because handover occurs in dynamic work situations, involves multiple nurses, and carries a risk of information loss. SBAR helps nurses organize information systematically, from the patient's current condition and clinical background to assessment findings and recommendations for follow-up care (Pazar et al., 2024; Kosim & Saimi, 2025).

Although overall compliance improved, the Background and Assessment components remained the weakest. In Background, nurses did not consistently communicate relevant clinical history, therapies, and previous information in full. In Assessment, changes in condition, nursing problems, and patient risks were not always

synthesized into a clear clinical analysis. These findings indicate a gap between following the handover sequence and being able to synthesize information. Case-based coaching, simulation using patient scenarios, direct feedback, and competency assessment should therefore be continued so that nurses do not merely report data but also interpret their significance for the receiving nurse.

Patient involvement in bedside handover also requires further strengthening. Bedside handover is not simply the relocation of handover to the patient's bedside; it should allow patients and families to confirm information, express concerns, and understand the care plan. When patients remain passive listeners, the patient-centered value of bedside handover is not fully realized. Nurses should therefore be trained to use understandable language, protect patient privacy, and select information that can be safely discussed in the presence of patients and families.

From a nursing management perspective, successful implementation is strongly influenced by the consistent application of the planning, organizing, actuating, and controlling (POAC) functions. Planning is required to develop the SOP, indicators, and audit format. Organizing is needed to assign the roles of the head nurse, handover champions, and quality team. Actuating is carried out through training, simulation, and mentoring. Controlling is implemented through audits, supervision, and regular feedback. Without consistent control, the improvements achieved may be temporary.

This article has several limitations. A quality improvement design without a control group cannot establish a strong causal relationship. The evaluation was conducted in a single hospital over a relatively short period, which limits the generalizability of the findings. Unit audit summaries reported overall performance across the three cycles but did not retain separate post-intervention counts of compliant events for each component. Consequently, some item-level findings were reported descriptively based on observation notes, interviews, and the FGD. Patient outcomes, including satisfaction, perceived safety, incident occurrence, and continuity of care, were also not evaluated in depth. Future projects should use an electronic checklist that records the frequency of each item and should incorporate patient outcome indicators and longer-term evaluation.

Conclusion and Recommendation

Nursing management strategies involving the development of an SBAR-based bedside handover SOP, communication training, use of a standardized documentation format, appointment of handover champions, and regular supervision and audits contributed to improved bedside handover implementation in the inpatient unit. Implementation increased from 68% to 90% after the intervention. However, the quality of clinical communication in the Background and Assessment components requires further strengthening so that bedside handover functions not merely as an administrative routine but as a practice that genuinely supports patient safety, continuity of care, and patient-centered care.

Regular case-based SBAR training, direct coaching during handover practice, monthly handover quality audits, individual and unit-level feedback, and integration of bedside handover indicators into the hospital's quality and patient safety program are recommended. The hospital should also ensure that patient involvement is implemented while protecting privacy, information security, and each patient's readiness to receive clinical information.

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Declaration of conflict of interest

The authors declare no competing interests.

Declaration on the Use of AI

No AI tools were used in the preparation of this manuscript.

Data Availability Statement

Data sharing is not applicable to this article.

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