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Nurse Champions as Change Agents for Bedside Handover Compliance: A Case Study

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Abstract

Background: Bedside handover is an essential element of effective nurse-to-nurse communication to ensure patient safety. A preliminary assessment at Hospital X, supported by previous literature, identified limited knowledge, heavy workloads, and the absence of evaluation and appreciation systems as key barriers to optimal bedside handover implementation.
Objective: This study aimed to identify the implementation of the Nurse Champion role in improving nurses' compliance with bedside handover at Hospital X using Kurt Lewin's Three-Step Change Model (Unfreeze–Move–Refreeze).
Methods: This case study was conducted in the medical-surgical inpatient unit of Hospital X from 8 September to 1 October 2025 using Kurt Lewin's Three-Step Change Model. Baseline observations were conducted from 8–14 September 2025, followed by semi-structured interviews with four Primary Nurses on 19 September 2025. The intervention included bedside handover socialization (24 and 26 September), appointment of a Nurse Champion (24 September), checklist-based monitoring integrated into the shift workflow (24–30 September), implementation of reminder stickers, and a reward program (1 October). Nurses' compliance with bedside handover was evaluated at the end of the intervention.
Results: Following the intervention, compliance across the 9P bedside handover components varied. The highest compliance was observed for *Plan and Partnership* (98.76%) and *Patient Comfort* (92.28%), whereas *Personal Hygiene* and *Environment* showed the lowest compliance (26.44%), indicating that these aspects were less consistently addressed during bedside handover.
Conclusion: Therefore, the implementation of Nurse Champions based on Kurt Lewin's Change Model was associated to improved compliance with 9P bedside handover and fostered sustainable behavioural change through enhanced motivation, appreciation, and a collaborative work culture in nursing practice.

Keywords: Bedside Handover, Change Agent, Kurt Lewin Change Model, Nurse Champion, Nurse Compliance.

INTRODUCTION

Bedside handover is a form of patient handover that occurs at the bedside, where the nurse reports patient condition to colleagues and the patient can be actively involved in the process. Its main purpose is to improve patient-centered care (PCC) through open and collaborative communication between patients, families, and nursing staff (1). Studies conducted overseas demonstrate that bedside handover is both practical and advantageous for enhancing patient safety. Malfait reported the level of nurses' compliance with Structured Content Protocol as 83.63% in seven hospitals in Belgium. Ghosh found in a Western Australian study that patient and family involvement in *bedside handover* is important to improve patient communication and safety, but implementation is still variable across facilities due to organizational factors and staff readiness. Other studies have also suggested that bedside handover gives patients a sense of security, as all staff share the same understanding of the patients' clinical condition (2–5)

In Indonesia, the implementation of bedside handover has shown mixed results. Research by Maurissa & Yuswardi found that this practice has been implemented in Banda Aceh, but other studies indicate that communication is not optimal with patient satisfaction rates below 90% (6,7). Ismuntania also reported that some nurses do not fully understand the benefits, flows, and barriers to *bedside handover*. The results of observations by Damayanti showed an implementation achievement of 78.47% with the lowest score in the Assessment step, influenced by suboptimal supervision, lack of supporting instruments, and low nurses' understanding of the SBAR method. Whereas *bedside handover* closely related to the achievement of the target *International Patient Safety Goals* (IPSG) which emphasizes the importance of effective communication and prevention of unexpected events in health services (8–13).

Efforts to improve compliance with *bedside handover* can be facilitated through the role *Nurse Champion* as agents of change. *Nurse Champion* is a nurse with a high commitment to the implementation of *evidence-based practice* (EBP), which serves as a *role model*, mentors, as well as drivers of innovation in work units (14,15). These roles can be adapted to the needs and characteristics of the organization, both on a functional basis (e.g. *Care Champion*, *Organizational Change Champion* or *Administrative Champion*), focus field (*Hand Hygiene Champion*, *evidence-based practice champion*, *Innovation Champion*), as well as position positions (*Nurse Educator Champion* and so on). Some studies have shown that increased adherence to evidence-based clinical practice is only seen significantly after engagement *Champion* in the implementation process. It has also been shown that champions tend to have longer tenure in the organization, more work experience, technical competence, and knowledge of the organization (16). Therefore, the Nurse Champion was selected from the Primary Nurses with the highest clinical career level (Perawat Klinis/PK).

The study of Clark shows that the involvement of *Champion Unit* in implementation *Nurse Bedside Shift Report* (NBSR) contributes significantly to the success of implementation through mentoring, auditing, and ongoing feedback forums (17). Previous research has proven that Kurt Lewin's Three-Step Change Model (Unfreeze–Move–Refreeze) approach is effective in supporting organizational change processes, including in improving the implementation of bedside handovers (9,18).

METHODS

Study Design

A qualitative case study design guided by Lewin's Change Theory was employed to explore barriers and facilitators of bedside handover implementation and to evaluate the role of Nurse Champions in improving nurses' compliance with bedside handover practices. The intervention was guided by Lewin's Change Theory and included education on the 9P bedside handover protocol, the appointment of Nurse Champions as change agents, and a reward-based motivation system. The implementation process followed the unfreeze, movement, and refreezing stages to identify barriers, facilitate practice adoption, and ensure the sustainability of bedside handover implementation.

Participants

The study was conducted in a medical-surgical inpatient ward of a teaching hospital in Depok City. The intervention involved four Primary Nurses (PNs) who served as Nurse Champions and 16 Associate Nurses (ANs) who participated

in bedside handover implementation. All Primary Nurses held a professional nursing degree (Ners) and had 2–6 years of clinical experience. The Associate Nurses participated in bedside handover according to their scheduled shifts and were observed by the Nurse Champions during the intervention period.

Intervention protocol

The intervention was implemented using Lewin's Change Theory, consisting of the unfreezing, movement, and refreezing **stages.** During the unfreezing stage, baseline observations of bedside handover were conducted from 8–14 September 2025, followed by semi-structured interviews with four Primary Nurses on 19 September 2025 to identify barriers to bedside handover implementation. The identified barriers included limited nurses' knowledge, the absence of an evaluation and recognition system, and inadequate environmental support.

During the movement stage, education and socialization on the 9P bedside handover protocol were conducted on 24 and 26 September 2025 for 20 minutes. The sessions covered the objectives of bedside handover, the 9P components, nurses' roles during bedside handover, and documentation procedures. The sessions covered the nine components of bedside handover, including greeting, identification, patient comfort (complaint, pain and sleep assessment), personal and environmental hygiene, personal diet, potty and pee, patient safety, position, puncture and pump, plan and partnership (patient and family involvement in care planning), and prayer and spiritual support. Four Primary Nurses were appointed as Nurse Champions based on their leadership roles and clinical competency. The Nurse Champions were responsible for providing reminders and observing bedside handover practices using the 9P observation checklist during their scheduled shifts, and documenting nurses' compliance throughout the intervention period (24–30 September 2025).

During the refreezing stage, implementation was reinforced through routine checklist reporting, collaborative supervision between the Nurse Unit Manager and the Nurse Champions, and a recognition program. Compliance scores from the observation checklist were used to determine the "Nurse of the Week", who received recognition as part of the reward system. To maintain fairness and minimize potential stigma among non-winning staff, the recognition system was based on objective criteria, including bedside handover compliance scores and the number of stickers collected during the implementation period. The recognition was intended to encourage participation and acknowledge positive engagement in bedside handover practices rather than to create competition among staff. Although individual staff members with the highest scores received recognition, non-winning staff were not perceived negatively or labelled as less competent. In addition, appreciation was extended at the ward level by providing snacks for the ward staff to acknowledge collective efforts and encourage teamwork in sustaining bedside handover implementation. A final evaluation of bedside handover compliance was conducted at the end of the intervention period.

Interview guideline for qualitative study

A semi-structured interview guide was developed to explore nurses' experiences and perceptions regarding bedside handover. The interview questions focused on four main areas: (1) nurses' roles and experiences in implementing bedside handover, (2) perceived impacts of bedside handover on patient care and communication, (3) challenges and barriers encountered during its implementation, and (4) recommendations for improving bedside handover practices and enhancing nurses' engagement. Additional probing questions were used to clarify responses and obtain more in-depth information.

Data Collection procedure

Data were collected between September and October 2025 through direct observation, document review, and semi-structured in-depth interviews. Interviews were conducted face-to-face with four primary nurses on September 19, 2025. The interview guide explored nurses' roles in bedside handover, perceived impacts on patient care, barriers to implementation, and recommendations for improvement. Follow-up questions were used to clarify and deepen participants' responses. Each interview lasted approximately 10–20 minutes and was audio-recorded with participants' consent. Although the interviews lasted approximately 10–20 minutes, sufficient information was obtained as the interview guide was specifically designed to

explore key aspects of bedside handover implementation, including nurses' understanding, perceived benefits, barriers, and recommendations for improvement. Data richness was further supported by repeated review of the audio recordings and transcripts during the analysis process.

Additional data were obtained through ward observations, discussions with the Nurse Unit Manager, and a fishbone analysis to identify factors contributing to low compliance with bedside handover practices.

Data Analysis

Qualitative data were analysed using thematic analysis. Interview transcripts were reviewed repeatedly to achieve familiarity with the data, followed by coding and categorization of meaningful statements. Similar codes were grouped into subthemes and broader themes. To ensure qualitative rigor, the primary researcher conducted the data analysis independently through a systematic and iterative process. The interview recordings were transcribed verbatim and reviewed repeatedly alongside the transcripts to achieve familiarity with the data. Meaningful statements relevant to the research objectives were identified and assigned initial codes. Similar codes were compared, refined, and categorized into subthemes and broader themes. A coding book was developed to document the codes, definitions, and supporting quotations. The analysis process, including coding decisions and theme development, was documented as an audit trail. The credibility of the findings was supported through data triangulation by integrating data from semi-structured interviews, direct observations, and document reviews. Reflexivity was maintained by the primary researcher through reflection on personal assumptions and potential biases during data collection and interpretation. Five major themes emerged from the analysis: (1) understanding of bedside handover, (2) knowledge of the bedside handover standard operating procedure, (3) perceived benefits of bedside handover, (4) barriers to implementation, and (5) support and recommendations for improvement.

Ethical Considerations:

In this study, formal ethical committee approval was not obtained. However, permission to conduct the study was obtained from the hospital through the Education Coordination Committee and the head nurse of the inpatient ward. Ethical principles were maintained through obtaining informed consent from all participants, ensuring confidentiality, and emphasizing voluntary participation throughout the study.

RESULTS

Unfreezing Stage: Intervention Preparation

The first phase of Kurt Lewin's theory of change, namely identifying and preparing for the need for change by (1) observing the room; (2) interview with *the Nurse Unit Manager* and *Primary Nurse*; and (3) Identify problems with the implementation *of bedside handover* by analysing *fishbone* diagrams.

Observation in the X-floor inpatient room was conducted from September 8 to 14, 2025. During the observation period, the BOR (Bed Occupancy Rate) was calculated for 6 days and was 96%, with a total bed capacity of 33. A total of 12 bedside handover opportunities were observed, consisting of two handover sessions per day over the 6-day observation period. All observed handover opportunities (12/12; 100%) were categorized as "not carried out." "Not carried out" was defined as the absence of bedside handover implementation according to the standard operating procedure, in which handover was conducted only at the nurse station without continuation of information exchange at the patient's bedside. Although nurses subsequently visited patients, these visits were conducted independently and did not involve a structured bedside handover process.

During the observation period, the author also observed the management function in the room while taking one day for an informal interview with the NUM (*Nurse Unit Manager*) without voice recording. The results of observation and informal interviews with NUM (*Nurse Unit Manager*) are presented in table 1.

A semi-structured in-depth interview was conducted face-to-face by the author with 4 Primary Nurses on the X floor on September 19, 2025. The thematic analysis process is then carried out in stages to transform the raw data into different themes and sub-themes through interview transcripts. The themes and subthemes of the interviews are presented in table 3.

Table 1. Results of Informal Observation and Interview with NUM on Floor X

Management Functions	Result
Planning	1) There is already an SPO 9P bedside handover available at RS X 2) There has been no monthly routine evaluation of the implementation of bedside handover
Organizing	All nurses in the room have a written description of duties at the SPO
Staffing	There is no formal appreciation system (e.g. staff of the month or special awards related to bedside handover)
Actuating	1) NUM routinely reminds PN and AN to conduct bedside handover during safety briefings 2) There is no monthly special supervision or evaluation for bedside handover 3) There is no nurse champion role in the room
Controlling	1) Bedside handover evaluation instruments are not yet available 2) There are no monitoring system and routine feedback on the implementation of bedside handover

Table 3. Thematic Analysis of Themes and Subthemes from the Interview

Theme	Subtheme
Understanding Bedside Handover	Definition and purpose of bedside handover Observation of the patient's condition directly 6P element in bedside handover*
Knowledge of SPO (Standard Operating Procedure) Bedside Handover	Lack of understanding and exposure to SPO at Hospital X
Benefits of Bedside Handover	Improved patient safety Improve communication between nurses Improve patient communication and trust
Obstacles in the Implementation of Bedside Handover	Workload and time constraints Lack of compliance and prioritization Inconsistent execution between shifts
Support and Suggestions for Improvement in the Implementation of Bedside Handover	Strong supervision Visual and verbal reminders Socialization and training for new nurses Addition of human resources and division of workload

*The term "6P" was retained during coding because it represented participants' actual understanding of bedside handover. The hospital standard operating procedure uses a 9P framework.

Theme 1: Understanding Bedside Handover

From this theme, three sub-themes were found through the thematization process, which are as follows:

1) Definition and purpose *of bedside handover*

   Based on the results of the interviews, it shows that nurses understand *bedside handover* as a process to re-confirm the operant information according to the patient's actual condition. This is reflected in the following statement:

   "Bedside handover is how we hand over the patient's condition from the previous shift to the next shift, like that." (P1)

   "The bedside handover is just to verify if what we say about the state of the patient is right or wrong." (P4)

2) Observation of the patient's condition directly

   Based on the results of the interviews, it was shown that the nurses emphasized the importance of seeing patients directly to avoid misinformation. This is reflected in the following statement:

"Besides the handovers in the room, we need to know what the real bedside situation is like." (P2)

"Ask the patient directly about their condition." (P3)

3) 6P element in *bedside handover*

Participants commonly described bedside handover using the 6P framework, despite the hospital's standard operating procedure requiring the implementation of 9P components. This is reflected in the following statement:

"Usually, we have 6 Ps: Pain, urination/defecation, comfort, patient safety, planning, and IV access status." (P1)

"But, from the Clinical Care Manager merely emphasizes the 6Ps..." (P2)

Theme 2: Knowledge of SPO (Standard Operating Procedure) Bedside Handover

From this theme, one sub-theme was found through the thematization process, which is as follows:

1) Lack of understanding and exposure to SPO
Based on the results of the interviews, it was shown that nurses had never read in full and only received information through NUM *(Nurse Unit Manager)* or CCM (*Clinical Care Manager*). This is evidenced by the statement below:

""I think there is a bedside handovers' standard, but I've never read the regulation. It's just instructions..." (P1)

"I don't think I've ever seen the standard operating procedures for bedside, but from the Clinical Care Manager, we emphasize the 6Ps..." (P2)

"Honestly, if you look at the SOP directly, that's fine. But if it's directed by the Head of the Room, it's recommended to do it at the bedside..." (P3)

"There was the 6P earlier, but I forgot even though I was given reminders often." (P4)

Theme 3: Benefits of Bedside Handover

From this theme, three sub-themes were found through the thematization process, which are as follows:

1) Improved patient safety
Based on the results of the interviews, it was shown that the nurse was aware *of bedside handovers*, helping to verify the action and reducing the risk of patient error. This is reflected in the following statement:

"Especially for patient safety. For example, if the name bracelet isn't on, we can double-check during the bedside handover..." (P1)

"If we don't do bedside handover, we won't know if the patient's wristband is still there. Well, that's an example. Falls are a common risk, for example, when a patient falls. Perhaps with bedside handover, we can confirm this..." (P4)

2) Improved nurse communication

Based on the results of the interviews, it was shown that nurses assessed *that bedside handover* could strengthen coordination and clarity of information. This is reflected in the following statement:

"It's important because sometimes we just talk about it, but it's not actually done on the patient. So, we need to verify and double-check whether it's been done on the patient." (P1)

"For example, if it's not at the bedside, what is transferred depends on the patient's condition." (P3)

3) Improved patient communication and trust

Based on the results of the interviews, it was shown that nurses felt a positive effect on the nurse-patient relationship after doing *bedside handover*. This is reflected in the following statement:

"I think it's definitely true, because by introducing ourselves to patients, it increases the patient's trust in us..." (P2)

"Because at bedside, the family feels involved, meaning they know who the nurse handling the patient at that time is..." (P4)

Theme 4: Obstacles in the Implementation of Bedside Handover

From this theme, three sub-themes were found through the thematization process, which are as follows:

1) Workload and time constraints
   Based on the results of the interviews, it was shown that nurses felt that the most dominant obstacle was the workload. This is reflected in the following statement:

   "One of the obstacles is being lazy about seeing patients. Maybe it's because there's too much administrative planning..." (P1)

   "...Because on the X floor, the workload is quite heavy, there's a lot of total care and maybe a lack of awareness among the nurses." (P2)

   "Yes, it's due to time constraints and workload..." (P3)

   "...For example, if something isn't done yet because we're pressed for time, while the patient is about to have surgery or is already asleep, this is like shift work from day to night. Especially if there's a shortage of staff, so one nurse can handle 7-8 patients... and that's a heavy load too, because we have to keep up with planning." (P4)

2) Lack of compliance and prioritization
   Based on the results of the interviews, it was shown that nurses felt that *bedside handover* was time-consuming, so it was considered not a priority. This is reflected in the following statement:

   "...but there's other work that I think bedside handovers take longer, so I'll just do the TTV later. So, I feel like it's not that important." (P1)

   "In terms of human resources, we each handle seven patients. It's also because of the workload. Because on the X floor, the workload is quite heavy, there's a lot of total care, and perhaps the nurses' awareness is also lacking." (P2)

   "Personally, I think it's still lacking. Because sometimes compliance is lacking. For example, if I'm asked to be on the bedside, I'll say, 'Oh, no, I don't have to,' because we're so busy with planning. So I feel like bedside time isn't necessary because I already trust them." (P3)

3) Inconsistent execution between shifts
   Based on the results of the interview, it was shown that the nurse stated that *the bedside handover* was only carried out on the *morning shift*. This is reflected in the following statement:

   "Usually, bedside handovers are orderly in the morning, but they're rare during the day or at night." (P3)

   "Bedside handovers are rare from day to night because the patients are sleeping." (P4)

Theme 5: Support and Suggestions for Improvement in the Implementation of Bedside Handover

From this theme, four sub-themes were found through the thematization process, which are as follows:

1) Strong supervision
   Based on the results of the interview, it was shown that the interviewees considered the need for regular supervision. This is reflected in the following statement:

   "Supervision is important. Even if there's no supervision, we'll need assessments, and reminders are important too..." (P2)

   "There needs to be a strict person in charge..." (P3)

2) Visual and verbal reminders
   Based on the results of the interview, it showed that the nurse felt that verbal reminders had been given but were considered less effective without direct supervision. This is reflected in the following statement:

   "Reminders, I think we've been given them often. My suggestion is to do it together. So, per wing, not just the person handling the patient doing the handover. Just a reminder doesn't mean checking each person individually to see if they're at bedside. That's it." (P1)

   "...if you want, you can put up a poster like that so every handover in the room is visible." (P3)

3) Socialization and training for new nurses
   Based on the results of the interviews, it was shown that the nurses suggested to improve the understanding and consistency

of *bedside practices*. This is reflected in the following statement:

"We've already done outreach. At that time, the new ones were also trained to maintain bedside handovers." (P3)

"That's great. It's also a reminder for others, for example, that bedside handovers are a point that needs to be emphasized. Especially since the new ones don't know that there's a bedside handover SOP." (P4)

4) Addition of human resources and division of workload
Based on the results of the interviews, it was shown that nurses felt that they lacked manpower, making *bedside handovers* not optimal. This is reflected in the following statement:

"If the workload is really heavy, we can find a solution to divide it evenly, perhaps by adding staff. Because the workload can be divided. But if there are only a few people on duty, we're also confused about how to divide it up." (P4)

After conducting observations and interviews, the problem was identified using the fishbone diagram. The results of the fishbone diagram analysis are attached in Figure 1, which illustrates that nurses' non-compliance with the implementation of *bedside handover* is caused by various interrelated factors seen in the aspects of *man, material, measurement, method, environment*, and *management*. The man aspect includes limited knowledge of bedside handover SOPs (not all have read them), nurses still realizing bedside handover is unimportant, and high workloads (one nurse can handle 6-7 patients). The measurement aspect, namely, the assessment of nurses' compliance with bedside handover implementation, has not been standardized. The environmental aspect includes a high administrative burden, with nurses spending more time on computers than with patients, and suboptimal bedside support.

The material aspect includes the lack of visual media or practical bedside handover guidelines in the ward. The method aspect includes the lack of a nurse champion role in bedside handover, 0% achievement of bedside handover implementation observations, and the lack of a specific evaluation instrument (checklist) for bedside handover. The management aspect includes the lack of staff appreciation (such as Staff of the Month) in the ward, and the lack of linking staff appreciation to bedside handover.

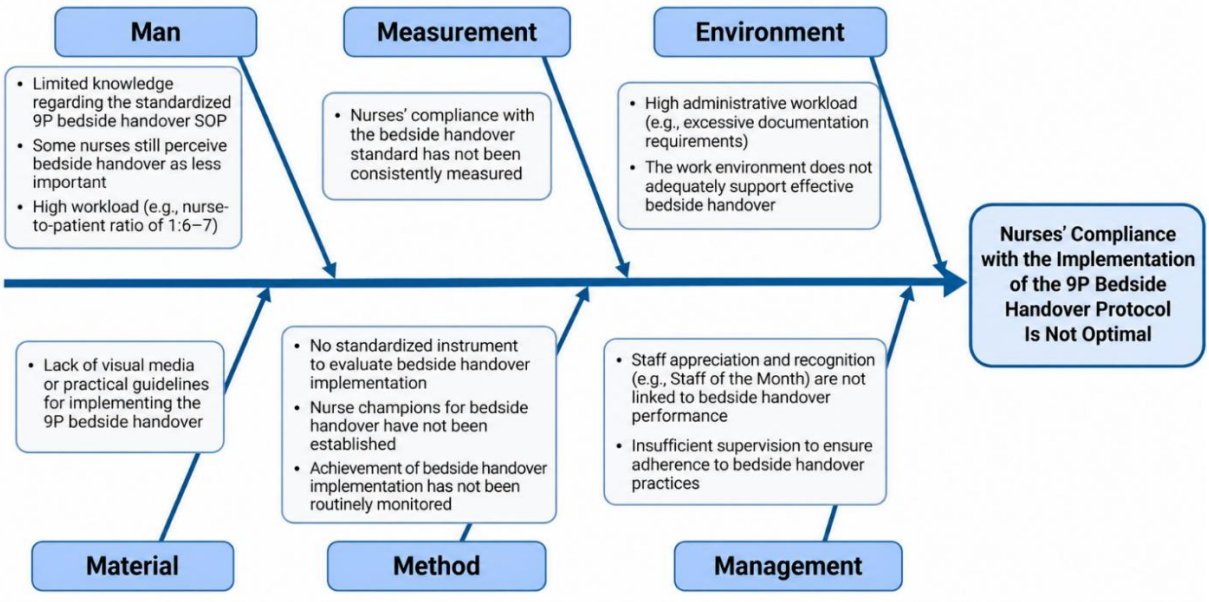

Figure 1 Fishbone Diagram Analysis Bedside Handover Implementation

Movement Stage: Implementation of the Nurse Champion Role

The second phase is movement (implementing the role of nurse champion). The activities in this second phase consist of (1) compiling the Planning of Action (PoA); (2) Socialization of the implementation of the role of nurse champions in bedside handover compliance; (3) Provide a checklist and special button pin to the Primary Nurse as a Nurse champion; (4) Attach bedside handover posters on both wings of the ward; (5) Directing nurse champions to carry out their duties as agents of change in the implementation of bedside handover; and (6) The author places points in the form of a round orange label in the patient's room that must be found by the nurse during bedside handover. The point system using orange labels was implemented as a motivational strategy to encourage nurse engagement during the implementation period. However, this approach may have introduced a Hawthorne effect, whereby nurses may have modified their behaviour because they were aware of being observed and evaluated.

Refreeze Stage: New Behavior Reinforcement

The refreezing phase in Kurt Lewin's theory of change is a stage of strengthening new behaviors so that they can be maintained consistently as part of the work culture. In this study, refreezing consists of several activities, namely: (1) Carrying out bedside handover consistently by using checklist reports as a compliance monitoring tool; (2) Giving appreciation to nurses who actively participate in the implementation of bedside handover; (3) Organizing Nurse of the Week activities on October 1, 2025 as a form of appreciation for nurses with the best compliance; (4) Carry out the award presentation and attach appreciation posters on the appreciation board as a form of strengthening motivation and positive work culture; and (5) Maintain the sustainability of the intervention through collaboration between the Nurse Unit Manager and the Nurse Champion.

The author also solicited feedback from participants regarding the implementation of Nurse Champion through written messages and recorded formal interviews, as reflected in the following:

> *"By the way, thank you for the award. I'm just an implementer... being able to bring in a management interest program that I thought would be boring, but it's actually interesting."* (P3)

> *"Having this Role Champion is a refresher for the nurses, so they're motivated because there's a reward. Hopefully, in the future, having a Role Champion can become a habit and be done every shift."* (P4)

> *"Wow... It's increased my ambition to do bedside handovers more often because there are orange stickers affixed to the patient's room. It's also helped me re-understand the steps of the 9P bedside handover, as so far, most nurses have only focused on the planning aspect. It's also increased my awareness of the patient's environment because the researcher placed the appreciation stickers in different locations each day."* (P5)

In addition to the four primary nurse interviews, one associate nurse (P5) provided supporting feedback during the implementation process. This feedback was used as contextual information to enrich the interpretation of findings and was not considered as a separate interview participant.

The Nurse Unit Manager (NUM) and Primary Nurse collaborate to sustain the intervention. As a supervisor, NUM oversees bedside handovers to ensure that regular assessments and the point and award system meet their goals. The Nurse Champion, PN, continues bedside handovers with the Associate Nurse and compliance checklists for self-assessment and team evaluation. This mechanism allows the movement phase transformation to last and integrate into space's organizational culture. Thus, the NUM's oversight and the Nurse Champion's transformation can improve bedside handover uniformity.

Table 4. Bedside Handover Compliance Rate Based on 9P Components

9P Components	Total Executed (n)	Percentage (%)
Patient Comfort*	121	92.28
Personal and Environmental Hygiene	32	26.44
Personal Diet	111	91.73
Potty and Pee	102	84.29
Patient Safety	105	86.77
Position	100	82.64
Puncture and Pump	103	85.12
Plan and Partnership**	121	98.76
Pray	31	35.29
Total	826	75.92

*Patient comfort there are three items on the checklist sheet

**Plan and partnership there are two items on the checklist sheet

The results of this study present the extent to which the implementation of bedside handover has been carried out by nurses with the support of the role of Nurse Champion. Observations were carried out for one week using a checklist containing nine bedside handover components that have been standardized in the standard operating procedures of RS X. Therefore, the total observations (denominators) differed across components because not every checklist item could be assessed in every bedside handover. During each observation, every checklist item was scored according to its predefined criteria. The Patient Comfort component consisted of three items (maximum score = 3), Plan and Partnership consisted of two items (maximum score = 2), whereas the remaining components consisted of one item each (maximum score = 1). Compliance for each component was calculated by dividing the total score obtained by the maximum possible score across all assessable observations during the one-week observation period and expressed as a percentage. Microsoft Excel was used for data tabulation and percentage calculations.

$$Compliance\ (\%) = \frac{\sum Score\ component}{N\ x\ Smax}\ x\ 100$$

Where:

- X_i= score obtained for each observation of the bedside handover component.
- $\sum X_i$= total score obtained for the bedside handover component across all observations.
- n= total number of assessable bedside handover observations for the respective component.
- $S_{\max}$= maximum possible score for the bedside handover component (Patient Comfort = 3; Plan and Partnership = 2; all other components = 1).

Table 4 presents data that the implementation of bedside handover with the support of Nurse Champion has the highest adherence to the patient comfort (n = 121, 92.28%) and plan (n=121, 98.76%) components and has the lowest adherence to the personal hygiene and environment components (n = 32, 26.44%).

DISCUSSION

The process begins at the Unfreeze by conducting observations and interviews in the field. The results of observation and interviews were then identified by diagram analysis Fishbone. This stage is in line with research conducted by Damayanti et al., (2021) where the stages Unfreezing Starting with observation and interviews in the implementation of supervision and socialization bedside handover at RS X (9). The same thing is also done by Magdalena et al., (2025) who take the Kurt Lewin approach in the development of guidelines Handover at the University of Indonesia Hospital. At the stage Unfreezing, This research also conducted observations and interviews (19).

Subsequently, Nurse Champion assumes the role of an agent of transformation for peers during

the bedside handover. This aligns with the studies performed by Kaasalainen et al. (2015) and Goedken et al. (2019) (14,20). Furthermore, the program incorporates a points and rewards system for both incoming and outgoing nurses who perform bedside handovers accurately. In this framework, the writer positions "points" as circular orange markers within the patient's room that the nurse is required to locate during bedside handover. This aligns with the study performed by Clark et al. (2020), which reinforces the findings of Boshart et al. (2016). Through this approach, nurses are not only intrinsically motivated to improve compliance but also enjoy the process of change through an element of fun competition. This program fosters the spirit of active participation and creates a positive work atmosphere, thereby supporting behaviour change in accordance with the goals at the stage Movement in the model of Kurt Lewin (21). The use of point-based reinforcement may have influenced nurses' behaviour during the observation period. The point system with orange labels was a motivational strategy to stimulate nurse engagement during the implementation period, which may have resulted in a Hawthorne effect, where nurses changed their behaviour because they were aware they were being observed and evaluated. In accordance with research by Pursell et al. and Nguyen et al. educational interventions, professional support and visible monitoring approaches have been demonstrated to improve healthcare workers' awareness and compliance with recommended clinical practices as people tend to change their behaviour when they are aware of being observed, the so-called Hawthorne effect (22,23). Therefore, improvements in compliance should be interpreted within the context of the intervention period, as the sustainability of bedside handover practices after discontinuation of the reinforcement system was not evaluated. Future studies should include longer follow-up periods to assess whether compliance is maintained over time.

In this study, Refreezing carried out by consistently implementing bedside handover through the report checklist and give appreciation to nurses who actively participate in bedside handover 9P and maintain the sustainability of interventions through collaboration between Nurse Unit Manager and Nurse Champion. Positive feedback was also given by nurses in the implementation Nurse Champion. This is in line with a literature study conducted by Sultan & Yuly Peristiowati (2023) that the performance of nurses, especially in hospital inpatient rooms, can be improved through various ways, including by giving awards (reward) and motivation in various forms (24). In addition, these findings are also in line with the research of Novita et al., (2022) and Magdalena et al., (2025) (19,25).

The results of this study present data that implementation bedside handover with support Nurse Champion has the highest compliance on components Patient Comfort and Plan and have the lowest compliance on components Personal Hygiene and environment. However, throughout the literature search, the analysis of the discussion of the concept bedside handover 9P is still limited. This is because the 9P model appears locally specific and not widely validated against SBAR/SBAR frameworks.

CONCLUSION

The study found that implementing the Nurse Champion role using Kurt Lewin's Three-Step Change Model (Unfreeze–Move–Refreeze) was associated with improved nurses' compliance with bedside handover. The intervention, consisting of 9P bedside handover socialization, the establishment of Nurse Champions, and a point-and-reward system, supported nurse engagement, participation, and improvements in bedside handover practices. Continued improvement was supported through regular evaluation, appreciation programs such as "Nurse of the Week," and collaboration between Nurse Champions and the Nurse Unit Manager. The highest compliance was observed in patient comfort and planning components, while personal hygiene and environmental aspects remained lower. This case study provides local implementation lessons suggesting that organizational support, structured supervision, and recognition strategies may facilitate the continuation of Nurse Champion-led bedside handover improvement. Further studies across different wards and healthcare settings are needed to determine broader applicability.

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AUTHOR CONTRIBUTION

Study conception and design: Aisyah Rohie
Data collection: Aisyah Rohie
Data analysis and interpretation: Aisyah Rohie
Drafting of the article: Aisyah Rohie
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CONFLICT OF INTEREST

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