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Talk to Me – a Re-Standardization of Bedside Report

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A Dissertation Submitted to The Graduate School at the University of Missouri -St Louis
in partial fulfillment of the requirements for the degree
Doctor of Nursing Practice

August
2021

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Acknowledgements

I could not have completed this project on my own. I have had the support of leaders that have faith in me and have given me support along the way in this process. Annette, Tom, Melissa provided me with support and faith that I could achieve finality in this project. I am grateful for their leadership, faith, and support in me.

I am thankful for all the professors at UMSL that guided me along the way on my DNP journey. I am especially grateful to Dr. Susan Dean-Baar for being my project chairperson and giving me the push that I needed when I was feeling discouraged. Without her support, I don't think I would be where I am now.

The support of the hospital educators was especially helpful in getting this project off the ground. They helped tweak the surveys and observation tool. I especially would like to thank Angel Wilson for her assistance with promoting the survey and my project, as she was the educator on both units that I was studying.

My Center for Training and Development family was super supportive throughout the process of my project. Angela, Patty, Jeremy, Stacey, Donna, and MaryAnn were rocks of support as well as sounding boards when I needed them.

I also want to thank my extended family and friends. Your love and support have meant the world to me as I completed this journey. Whether I needed you to listen, or you just sent me a kind word or message, you were part of this process too and I could never thank you enough for that.

Dedication

This DNP project is dedicated to my husband and children who endured this path with me. They endured every night that I had to dedicate to homework, research, writing, and not to mention the exhaustion that went along with it. I also dedicate this project to my mother, Sharen Daley, who died in 2010. She instilled in me the importance of education and supported every dream I ever had. I know she would be proud of me achieving this dream. I also dedicate this project to my mentor, Patty Eppel. Without her utmost faith in me, I don't think I would have been able to achieve this. She has been my backbone of support in this process as well as an amazing mentor at work.

Abstract

The use of bedside shift report provides for an accurate exchange of information between healthcare providers. Bedside shift report has been shown to decrease call light usage, medication errors, patient falls, as well as increase patient and nurse satisfaction. The aim of this project was to re-implement the usage of bedside shift report on two units in a community hospital. The steps involved in this project were a preliminary survey followed by observations of the current process of bedside report. The next step was to educate regarding the importance of bedside report and its benefits. This was followed by another set of observations and a final survey. Lewin's three step change theory and the PDSA (Plan-Do-Study-Act) model were used to guide the project. Independent samples t-tests and chi-square goodness of fit tests were used to analyze the data. HCAPS (Hospital Consumer Assessment of Healthcare Providers and Systems) nursing care scores improved from below the 50th percentile in both units to most scores being above the 50th percentile for all areas regarding nursing communication. Both units also showed improvement in all critical areas of bedside report during the observations. The goal for all critical components included in the observations is completion 80% of the time, in the pre-observations this only occurred in 2 of the 14 items, for the post observations 10 of the 14 components occurred at least 80% of the time. All but two of the components of bedside report showed improvement and one of these items started above 80% occurrence and remained above the benchmark in the post-observation. The survey of registered nurse staff also showed improvements in satisfaction with last report given, nurse/patient relationship and patient satisfaction, and nurse/patient relationship and job satisfaction. The staff made substantial improvements in their bedside report process.

There are still improvements to be made and with further education and reinforcement, the process can be hardwired into daily process.

Talk to Me – A Re-standardization of Bedside Report

Bedside nursing report may occur in several health care environments, including hospitals, home health care, and long-term care. Hospitals are the most likely place, and most well-known, for bedside report to occur (Blouin, 2011; Jeffs et al., 2013). In the hospital, patients present with various needs and over the past decade, patients in the inpatient setting have become more complex, thus requiring higher levels of care. Patients that require higher levels of care also require coordination of care between multiple specialties to manage disease processes (Agency for Healthcare Research and Quality [AHRQ], 2013). Handoff report occurs when transferring care from one provider to the next. Communication is critical when performing patient handoff. The safety of the patient is essential because if clinician's handoff is inadequate, this can be a key contributor to adverse events (The Joint Commission [TJC], 2017). By utilizing bedside handoff report, we can reduce the risk of these events.

Although the hospital has a policy in place stating that bedside handoff report is to be completed, it is not consistently completed nor monitored. The Centers for Medicare and Medicaid (CMS) look at patient safety when deciding reimbursement for service. When bedside report is not completed consistently, crucial information could be missed that could directly affect the hospital's reimbursement from CMS. The practice that will be changed is to consistently implement bedside report policy, regardless of when handoff occurs, department to department or nurse to nurse.

Significance

It is the responsibility of the nurse to ensure a safe and effective patient handoff. Failure to provide this can result in medication errors, falls, and increased patient

complications (Zou & Zhang, 2016). Effective patient handoffs can also assist in a faster return to baseline for hospitalized patients as nurses are able to respond to patients needs more effectively and efficiently (Baker, 2010). Patient handoff also offers the time for nurses to interact effectively with the patient's family. The incoming nurse can update the patient and family regarding condition, plan of care, concerns regarding hospitalization, identifying goals for the current shift, and update the patient care board in the room. This helps build trust by encouraging the patient and family to take an active role in the bedside report process (Baker, 2010). The Joint Commission has established a National Patient Safety Goal for hospitals to implement standardized handoff practices, including time to ask and respond to questions (Zou & Zhang, 2016).

During bedside handoff, the communication between the nurses also becomes more effective. Bedside handoff ensures that the oncoming nurse continues with the plan of care from the off going nurse and that nothing is missed during report. Directly visualizing the patient together in the room allows the oncoming nurse to quickly complete a focused assessment with the off going nurse. Visualizing the patient together and completing a safety check ensures a smoother transition and workflow (Cairns, Dudjak, Hoffman, & Lorenz, 2013).

Communication lapses can lead to patient safety errors and errors in communication are a known cause of sentinel events in the hospital setting (TJC, 2017). The handoff of patients from one clinician to another is a high-risk time for gaps in communication to occur. Often, key components needed for care of the patient can be lost now, especially if report is not completed at the bedside (Carlson, 2013). An effective end of shift report can provide the oncoming clinician with the information needed to

care for the patient in a safe manner. Incomplete reports cause confusion for the patient, family, and leave large margins for error.

In a word, bedside report is what is best for patient safety. The number of preventable errors that occur every year is in the thousands, but even greater are the number that go unreported (Mardis et al., 2016). Preventable errors can lead to acute illness, chronic illness, disability, and even death. Bedside shift report responds directly to one of the Joint Commission's National Patient Safety Goals (Baker, 2010).

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is a standardized survey that has been used in hospitals since 2006. This survey measures the patient's perceptions of the care that they received. This survey is set up to produce data on the perspective of the patient that allows for objective comparison from hospitals on topics that are important to their consumers/patients. The results of these surveys are publicly reported which is an incentive for hospitals to improve their results/improve their quality of care (HCAHPS, 2019). The survey is administered via telephone, mail, or a combination of both. It has been recognized that answers to the survey questions may be influenced by the way that the survey is administered. It has been found that more favorable responses are given when the survey is administered via telephone. Most patients discharged from the hospital are eligible for this survey except for pediatric (under age 18) and patients admitted for mental health conditions. The HCAHPS survey does not address the needs of these specialized populations, thus the decision was made to omit them. The patients surveyed are randomly chosen and are contacted between 48 hours and 6 weeks after discharge. Hospitals must administer the survey every month of the year. The results are published on the Hospital Compare

website and are published for four quarters on a rolling basis. The survey results are designed to compare hospital to hospital, not for evaluation of staff members (HCAHPS, 2019).

Improved patient satisfaction is a quality indicator and a part of value-based purchasing. Improving patient satisfaction leads to better reimbursement for the facility. Evidence supports that bedside handoff benefits patients and families by increasing participation in care, improving communication, and promoting patient satisfaction (Wakefield, Ragan, Brandt, & Tregnago, 2012).

Literature Review

The need for standardized patient handoff between nurses to improve communication and increase patient satisfaction was the focus of this literature review. The review focused on looking at handoff tools such as SBAR (situation, background, assessment, and recommendation) to ensure key and important data was relayed between caregivers.

A review of literature was conducted using Cumulative Index of Nursing & Allied Health (CINAHL), MEDLINE, and EBSCO. Keywords such as bedside report, nursing handoff, shift report, nursing bedside report, nurse patient communication were used. The search terms *bedside report*, *handoff report*, *nursing report*, *nursing shift report*, and *nursing communication* were searched. Initially, 1,170 articles were returned, the list was then limited to journal articles and limited to years 2010-2021. Articles were rejected if they were not full text, not published in a peer reviewed journal, editorial articles, or poster presentation. Particular attention was paid to articles that spoke to standardization of the bedside report process or the usage of standardized tools such as SBAR for the

report process. Articles were assessed for relevance to bedside reporting and established protocols. Evidence based practice articles included information verifying the importance of bedside shift report and to identify reasons why staff would have reasons not to comply with the protocol. A total of fifty-two articles were kept for review (Appendix A).

Extensive research on the implementation of bedside shift report has been identified. The evidence review provides information to support the implementation of bedside shift report. The literature review addressed the evolution of bedside shift report from nurse to nurse report (away from the bedside) to the implementation of report at the bedside. As a result of sentinel events related to communication, The Joint Commission (TJC) identified handoffs between healthcare providers as a contributing factor to patient safety events (Radtke, 2013). The subsequent recommendation was to implement a standardized approach to communicate patient information to include discussion of patient care detail, engagement with patient and family, and opportunity to ask questions – all to occur at the patient’s bedside.

The literature review has shown that bedside report is a means of enhancing patient satisfaction as well as patient satisfaction scores, family perception and satisfaction of nursing staff (Vines, Dupler, Van Son, & Guido, 2014; Gregory, Tan, & Tilrico, 2014). Literature supports that bedside report increases staff accountability, increases patient safety, and improves staff communication during shift change (Radtke, 2013).

Anderson, Malone, Shanahan, and Manning (2014) completed an integrated review describing issues regarding implementation of the process of bedside handover report. The authors reviewed 45 articles. The articles were included if they were based on

research involving bedside handover involving nurses and midwives between the years 2003-2013. The main issues with implementation identified were confidentiality, inclusion of the patient, and involvement of the multidisciplinary team. This review did identify a lack of published literature about the transfer of accountability and responsibility during bedside report. It was also found that the nurses were more concerned about confidentiality than they were the patients themselves. In the studies reviewed, the use of a structured tool was supported, but there is not one tool that is supported across all clinical areas.

A study by Scheidenhelm and Reitz (2017) looked at nurse compliance with bedside report; this study used the Studer Method. Tools from the Studer Group Toolkit were provided to the nurses, along with simulation of bedside report. The nurses were then monitored giving bedside report at 2 weeks and then at 1 and 3 months after implementation. The nurse compliance with bedside report increased. To sustain the results from this study, they continued with random observations.

Tobiano, Bucknall, Sladdin, Whitty, and Chaboyer (2018) evaluated how patient participation in bedside handover could be implemented. They looked at this from the perspective of the patient and the nurse. This study set out to address three sub-questions: What is the patient's role? What are the barriers to patient participation? What strategies will enable the patient to participate? They identified that the role of the patient was to listen, add, clarify, or ask questions or identify missed or wrong information related to nursing care or medical treatment. The barriers that were identified were the approach of the nurse, confidentiality, and discomfort of the nurse in encouraging patient participation. Strategies that were identified to enhance patient participation were: stand

close to the patient, two way communication in which patients were encouraged to speak and patients were listened to, sensitive information is communicated away from the bedside, and use video role play to increase confidentiality.

Catholic Health Initiatives (CHI) Franciscan Health System's Regional Hospital, a 26-bed long term acute care hospital (LTAC) was given the opportunity to participate in a clinical scene investigator (CSI) program with the American Association of Critical Care Nurses (AACN). The purpose of the project was to improve communication by standardizing bedside shift report at change of shift (Rogers, Li, Clements, Casperson, & Sifri, 2017). The study found that medication errors related to patient hand off decreased 80% and there was a 100% reduction in falls related to patient handoff. The hospital also experienced a 12% increase in family satisfaction and a 23% increase in patient satisfaction.

Novak and Fairchild (2012) conducted a literature review to determine if the use of a SBAR tool to deliver bedside shift report would enhance outcomes on a pediatric unit as opposed to nurses that provided report using a tool of their own choosing. The SBAR tool is used to facilitate prompt and appropriate communication. The evidence showed that there were many benefits to using the SBAR tool. There were financial savings from decreased falls, medication errors, and nursing overtime. The research also showed that bedside report gave the time for patients and families to get their questions answered. The patients were also always aware of who their nurses were for that shift (Novak & Fairchild, 2012).

Holly and Poletick (2013) completed a systematic review evaluating how it was determined what information was passed along during bedside report. The studies they

reviewed were qualitative studies. They included 29 studies that described the experiences and process involved with bedside report/patient hand off in acute care hospitals. They found that roughly 70% of the information passed along could be backed up with documentation. Multiple studies reported the incomplete nature of bedside report. It was also found that the medical record had more information than what was being relayed in bedside handoff, yet handoff contained information not available in the patient record. From their analysis, it was theorized that the best possible solution would be to use both methods for report (Holly & Poletick, 2013).

Mardis et al. (2016) completed a systematic review of the literature looking at the impact of bedside report on patients as well as the providers. They reviewed articles between years 2008-2014 and 208 articles were chosen for review. The articles chosen focused on shift to shift handoff of any professional, not just nursing, had either quantitative or qualitative data, and focused on bedside handoff. They grouped results by outcome measures: self-report measures (attitudes, beliefs, perceptions), process measures (describe actions performed), and outcome measures (describe condition or response to care). Thirty-nine relevant articles regarding bedside handoff were identified using their literature search. Many of the articles indicated improved satisfaction with bedside handoff, as well as fewer patient complaints related to handoff periods. They did find one study that reported all nurses agreed that bedside handoff violated patient confidentiality. The articles that addressed process outcomes found that there was a decrease in handoff time, overtime hours, call light activation, and call light response time in correlation with bedside handoff. The articles that addressed patient outcomes found that there was a decrease in falls during shift handoff. They also noticed a

reduction in clinical incidents, such as incidents involving medication administration, blood administration, and breach of infection control, in correlation to bedside handoff. One article did address potential detriments such as the fact that bedside handoff can be time and resource intensive and conversations using medical language can be anxiety provoking for patients. Nurses could also be hesitant to implement bedside handoff due to concerns regarding breach of confidentiality. In response to the issues raised regarding confidentiality, the authors did not find any studies that published concerns serious enough that would warrant not implementing bedside handoff.

Radtke (2013) reported the result looking at improving one area of a hospital's HCAHPS score. This study sought to improve the "nurse communicated well" score. The goal was to reach a 90% satisfaction rate. This unit was not using bedside handoff prior to this study. This study looked at the changes in satisfaction rates after the implementation of bedside handoff report. The results of the study showed an increase in the score from 75% to 87.6%, so even though the study did not reach the initial goal, they did improve in this area of patient satisfaction.

Faloon, Hampe, and Cline (2018) conducted a study evaluating the effectiveness of education on compliance of bedside report. The interventions in this study were a video, education handout, demonstrations, and verbal education. They found that bedside report increased to 81% by the 6-month survey. They also found that introductions increased to 100% by six months.

Wakefield et.al. (2012) looked at how one unit transitioned from a traditional way of giving report to giving report at the bedside with patient and family involvement. Patient satisfaction scores increased by an average of 11 points six months after

implementation. The follow up period was 23 months and the patient satisfaction scores averaged out to an increase of 6.9 points. The nurses agreed that bedside report was a better process, but not all nurses were on board. At the 23-month mark, it was noted that some nurses had converted back to the old way of giving report.

Jeffs et al. (2013) published a qualitative study looking at the experiences and perceptions of nurses associated with the implementation of bedside shift report. Their study was conducted in an inner-city acute care teaching hospital. Prior to implementation, the report process was either verbal at the nurse's station, taped, or writing information on a white board at the nurse's station. During implementation, each unit designated a unit champion to lead the implementation process. The unit champion was mentored by the professional practice team. They conducted a total of 43 interviews following implementation. The nurses reported being able to identify, stop, and/or correct potential and actual errors in care. Now that report was interactive, the nurses were able to ask questions for clarification and determine how informed the patient was on their care. The nurses were able to plan and set priorities for their patients easier because now that they were doing a quick assessment in the room, they could determine care needs on their team and determine who needed to be seen first. This study showed a very favorable outcome, but it was only conducted at one hospital and would need to be performed on a much larger scale to determine if the results are generalizable.

Zou and Zhang (2016) published a prospective study looking at the effectiveness of using a standardized nursing handoff form. They used a one group pre/post quasi-experimental design. The study was conducted on an inpatient medical unit in China, composed of 80 beds with a total of 45 nurses' working day and night shift. Prior to

intervention, the nurses used verbal handoff at the nursing station for report. The study implemented a standard form based on patient characteristics of the unit. The first part of the form consisted of patient demographics and the second part of the form consisted of patient specifics such as fall risk, oxygen, EKG monitor, tubes, and lines. This study looked at a total of 1963 admissions pre-intervention and 1970 admissions post-intervention. They found that handoff related errors decrease from 2.7 to 0.7 per 100 admissions. They also found a significant reduction in inpatient falls.

Problem Statement

Patient satisfaction scores revealed the need to improve in the areas of communication, specifically, in nurse – patient communication. In response, nursing administration has asked for a re-standardization of the bedside report procedure. The idea is that moving bedside report from outside the room to the bedside will improve patient satisfaction, the patient care experience, and increase satisfaction of the nurses (AHRQ, 2013b). To be successful in making this change, direct care providers must remain involved in the process. This project focuses on improving patient and nursing satisfaction by implementing bedside nursing report during shift change, which will in turn increase HCAHPS scores in the nursing communication realm.

PICOT

Bedside report is currently being performed in an inconsistent manner on two units, identified as Unit A and Unit B, leading to low HCAHPS scores as well as decreased nursing satisfaction scores. This study aims to look at: What is the impact on HCAHPS scores and nursing satisfaction following real time observations followed by targeted education regarding bedside shift report?

Definition of Terms

Bedside nurse: nurse that gives direct care to a patient, synonymous with staff nurse or registered nurse (RN).

Bedside shift report: A process that takes place when nurses exchange information, most often from one shift to another, related to safe and effective care in the presence of the patient (Cairns et.al., 2013). This can facilitate identification of errors, prevention of falls, and provide an opportunity for early recognition in decline in patient status (Boshart, Knowlton, & Whichello, 2016),

Change of shift: the time when the care of a patient, along with responsibility and accountability for the patient is transferred from one nurse to another. (Griffin, 2010).

Handoff communication: for the purpose of this project, this refers to the transfer of information from one health care worker to another for the purposes of caring for a patient (The Joint Commission, 2017).

HCAHPS Scores: The results from a 32-question survey sent to patients after discharge from the hospital. The survey is used to gather data for measuring patient perception of their hospital experience (HCAHPS, 2019).

Patient centered care: care planned with the healthcare team and the patient, in this model, the patient takes an active approach in the process and understanding of all health care decisions

Patient engagement: Patient engagement occurs when caregivers support patients in their decisions regarding their health care (AHRQ, 2013a).

Patient satisfaction: The extent to which patients are happy with their health care, both inside and outside the physician's office. This is a measure of quality and gives

insight to providers on the effectiveness of the care that is being provided (AHRQ, 2013b).

Situation-Background-Assessment-Recommendation (SBAR): the mnemonic SBAR is a structured process to facilitate communication among the members of a health care team, which ensures a standardized format to relay essential information during bedside shift report (Cornell, Grevis, Yates, & Vardaman, 2014).

Standardization: for the purposes of this project, standardization refers to relaying information during nurse-to-nurse handoffs using a systematic approach.

Theoretical Framework

Implementation of bedside report is guided by Lewin's Change Theory. This theory is comprised of three phases: unfreezing, changing, and refreezing. This theory allows for those affected by change to prepare for it, thus making it easier to absorb. Once the driving forces behind change is understood, work to strengthen it can occur, thus making the change a successful one (Wojciechowski, Pearsall, Murphy, & French, 2016).

The Plan-Do-Study-Act (PDSA) Cycle was used as a tool to guide this project. The purpose of using the PDSA tool is to be able to implement and test changes in a manner that is safe, timely, and cost effective. This tool allows us to learn very quickly whether the change we are implementing is going to work, or if we need to change our process (Reed & Card, 2016).

The basis of this approach is a four-step method to carry out a process of change: Plan: recognize an opportunity for improvement, plan a change, and estimate the impact of said change. Do: test the proposed change, perform a small-scale study, such as a pilot.

Study: review the results from the change and study what you have learned, and the information gained from the change. Act: make any needed changes to the process. If the change did not work, repeat the cycle with a different plan/change. If the change was successful, plan to roll out your change in a larger format. The PDSA cycle will be continuously repeated to improve any changes that are put in place (Cairns, et al., 2013).

Lewin's Change Theory

Lewin's three step model to change is seen as his contribution to organizational change. He saw these concepts as an integrated approach to analyzing, understanding, and bringing about change at the group, societal, and organizational levels (Burnes, 2004).

The first stage of Lewin's Change Theory is the Unfreezing stage. This stage involves preparing the organization/employees for the change that is going to occur and that adopting the change is important for continued successful survival (Ahmed, 2014). In this stage, you need to stress the need for change as well as motivate staff to accept the oncoming change. In this stage, communication is essential, as it will play a vital role in getting support and buy in for the new process (Juneja, 2015). While there may be multiple research studies citing the benefits of bedside report, there will still be multiple barriers to overcome in implementing such a process (Vines et.al., 2014). This is the stage that will be the most difficult and will face the most opposition.

In the changing stage, this is where training for the new process starts. This stage is a stage of transition. This is also the implementation stage. Acceptance of the new way of doing things has begun. Staff members are now "unfrozen", and the actual change has been put in place. In this stage, effective communication and encouragement is essential

to continue to endorse the change that has been put in place. This stage is not an easy stage to transition through, there will be many fears and uncertainties regarding the change being put in place, and thus it is important to have a strong support structure in place for the staff members (Juneja, 2015). The process of bedside report has been introduced to the staff and the focus now is on acceptance. It is also important to update the staff on how the change is affecting their unit. This is not a stage that happens overnight. Not everyone is going to fall in line “just because I said so,” there will still be late adopters that are still opposing change (Vines et.al, 2014).

The final stage in the change process is re-freezing. The staff has moved from a stage of transition to a stage of stability. The staff has accepted the change, it is now a part of their routine (Juneja, 2015). In this stage, the staff is consistently using the new process. At this stage, evaluations, surveys, debriefing sessions, meetings are all tools that can be used to identify concerns regarding the new process. It is important to continually receive staff feedback regarding the new process. In healthcare, things are always changing, and bedside report is no exception to that rule. This new process may need to be continually “tweaked” until it is molded to fit with a particular unit as not all units have the same needs (Vines, Dupler, Van Son, & Guido, 2014).

When the staff reach this stage, we should see an increase in patient satisfaction scores as evidenced by an increase in the patient satisfaction scores. At this point in time, the staff should be comfortable with the process and completing bedside report in the room with patient and family involvement should be second nature.

When applying Lewin's theory to this project, moving and re-freezing refer to analysis of the initial survey findings that will assist with the development of the education to be rolled out to the nursing staff.

Methods

Project Design

This is a pre – post observational project to improve the adherence of bedside shift report. The purpose of this quality improvement plan is to increase compliance with using bedside shift report leading to increased patient satisfaction scores. The first phase of the plan will involve a survey and observations of nursing staff. The observations will be conducted in real time of the nurses conducting bedside shift report. Observations will occur at shift change, both dayshift and nightshift. The purpose of the survey will be to obtain data from the bedside nurses regarding perceptions of completing bedside report. The second phase will be the education phase. All nursing staff will be educated on the process of bedside shift report via online education, huddles, one on one education, and videos. The final phase of the project will be another round of observations and a final survey post implementation. This set of observations will be much like the first. The same behaviors are being looked for, they will take place at shift change, both days and nights. The second survey will be to evaluate the nursing staff's thoughts regarding the implementation and benefits of bedside shift report. As a result of the increase in compliance with bedside report, it is also anticipated that patient satisfaction scores will improve. Patient satisfaction scores for both units in the study will be reviewed both pre and post implementation of bedside report education.

Setting

The project will occur in a 220-bed community hospital that provides multiple services to the community it serves. This hospital has approximately 13,005 admissions yearly; 102,300 emergency department visits yearly; and 6,379 surgical procedures yearly. The units selected were Unit A and Unit B. Between these two units, there are 88 staff members: two patient care managers, six assistant nurse managers, four charge nurses, 46 staff nurses, one staff educator, 22 patient care technicians, three student nurse technicians, and four unit secretaries.

Human Subject Review and Approvals

Survey participation was voluntary, and no personal identifiers were collected. Because the project administrator is an employee of the facility where the project is being conducted, Qualtrics was used to protect the participant's welfare. By using Qualtrics to administer and collect all survey results, the choice to participate in the survey is completely anonymous. The RN's on the two units were presented with an email inviting them to participate in the survey. This email can be found in Appendix B (post implementation survey email can be found in Appendix C). The email informed the RN's that responding to the survey was voluntary and implied consent to participate in research. The patients of the nurses being observed were also asked to give verbal consent. To observe the full bedside report process, the observer will need to be near the patient room and may hear protected information, thus patients were given the option to consent to participate in the study.

To protect study participants, the project was reviewed and approved by the Institutional Review Board (IRB) at University of Missouri – St Louis (UMSL) and at the community hospital where the project occurred.

Procedures

The goal of the project was to improve bedside report compliance by re-education regarding the process. The plan included a preliminary survey to the nursing staff, along with observations of the current bedside report process. The purpose of the survey was to obtain data from the bedside nurses regarding obstacles to completing bedside report. After all observations were complete, education was completed. All nursing staff was educated on the process of bedside report via online education, huddles, one on one education, and a video. The final phase of the project was another survey, as well as another round of observations to collect data on bedside report process. The goal of the second survey was to evaluate the nursing staff's thoughts regarding the implementation and benefits of bedside shift report.

The survey was sent to 46 registered nurses on two units of a 220-bed community hospital in the Midwest. The two units chosen have HCAHPS scores below the set achievement score for the hospital. The project administrator sent an email explaining the survey to the nurses as well as the Qualtrics link, all emails were sent via blind carbon copy (see Appendix B). In the email the nurses were asked to go to the link and complete the survey (Appendix D).

As both surveys were anonymous, demographics were collected pre and post observation, including years of experience, degree, tenure at the hospital, satisfaction with report given/received on day they filled out the survey, as well as questions surrounding quality of the report given. Nurse managers communicated the survey via staff meetings, email, and unit huddles.

The original survey results were gathered via a Qualtrics survey. The survey results were analyzed to plan the education effort. The education was given to the two pilot units that took the survey initially.

The staff was re-educated in multiple ways to ensure the greatest sustainment. The primary education was a PowerPoint assigned via SABA, the learning management system, with a post-test. This method was chosen because of the ease of monitoring for scoring and completion. Education was also completed during staff huddles and staff meetings. The power point used was the Guide to Engaging Patients and Families at the Bedside and Families at the Bedside developed by AHRQ (2013b).

Poster boards were made for the pilot units outlining the benefits of bedside report. A tip sheet, with plenty of copies provided, was supplied for each unit. The education also includes a three-minute video (Appendix E).

Once re-education was completed, and implementation of education took place on the pilot units, the nurses on the pilot units were re-surveyed. The second survey results were compared to the first survey results. The second survey was administered in the same manner as the first survey. After the second survey was administered, a repeat set of HCAHPS scores were collected.

The observations were collected by visual surveillance. The nurses were observed giving report at shift change. Nurses were observed on both day and night shift on both units. The observations were conducted over a two-week period, both pre and post educational intervention.

Data collected via bedside report observations was:

1. Was shift report conducted at the bedside?

2. Was oncoming nurse introduced to patient/family?
3. Was a safety check completed (check IV lines, tubes, drains, wounds)?
4. Was patient asked to participate in shift report?

Data was collected via direct observation on each unit, the researcher stood at the patient's door while report was being given and directly observed/listened. A checklist was utilized for each report observation (Appendix F). After the observations were completed, the nurses were asked to complete a post implementation survey (Appendix G). As with pre-implementation, an email explaining the survey was sent, along with the link to the survey (Appendix C).

Patient satisfaction scores were assessed using the HCAHPS survey, specifically the three questions addressing communication with nurses. The questions that were addressed were:

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
2. During this hospital stay, how often did nurses listen carefully to you?
3. During this hospital stay, how often did nurses explain things in a way you could understand?

Data Analysis Plan

Qualtrics was utilized to administer all surveys to protect the identity of the respondents. The survey remained open until 20 surveys were obtained. The HCAHPS scores are retrieved from prceasyview.com. The HCAHPS scores utilized were from July – September 2020, which was the three months prior to implementation and March –

May 2021, the three months after the bedside report education. No patient identifiers or patient information was used in the project.

Survey responses were downloaded into excel for analysis. Chi-square tests and dependent sample t-tests were used to analyze the data to determine statistical differences.

Results

The HCAHPS scores for both units at the start of the project were consistently lower than the average scores for the hospital. Table 1 illustrates the HCAHPS scores at the start of the project as well as the end of the project. For the hospital, all the HCAHPS scores did improve, but the p values did not show a statistically significant change. For Unit A, all scores improved, but the scores that had a statistically significant improvement, were nursing overall and nurse explain. For Unit B, again all scores improved, but this unit had two scores with statistically significant improvements, nursing overall and nurse listening.

Table 1: HCAHPS Scores pre and post educational intervention

HCAHPS Item	Pre-Education July- September 2020	Post Education March-May 2021	p-value
Hosp – Nurse Overall	79.96	81.97	0.33
Hosp – Nurse Respect	84.46	87.38	0.29
Hosp – Nurse Listen	78.22	80.33	0.33
Hosp – Nurse Explain	77.19	78.20	0.62
Unit A – Nurse Overall	77.01	85.78	0.03
Unit A – Nurse Respect	82.54	88.35	0.16
Unit A – Nurse Listen	77.12	84.49	0.19
Unit A– Nurse Explain	71.43	84.49	0.02
Unit B – Nurse Overall	74.47	82.83	0.04
Unit B – Nurse Respect	79.37	87.62	0.19
Unit B – Nurse Listen	72.65	81.38	0.04
Unit B– Nurse Explain	71.38	81.70	0.08

Table 2 highlights the demographics of the nurses that participated in the study. Prior to the educational component of the study, most nurses participating either had less than a year of experience or more than 10 years of experience. After the educational component, most participants had between two and three years of experience. The degree level of the nurses stayed consistent pre and post. The most common educational levels of the nurses were either associates or bachelor's degrees. For years at the hospital, this statistic followed years as a nurse. Many of the nurses were employed full time. The nurses were split evenly between Unit A and Unit B as well as working day shift vs. night shift.

Table 2: Demographic Data of project participants

		Pre % (n=20)	Post % (n=20)
Years as a nurse:	0-1	31.6	20
	2-3	15.8	40
	4-5	21	10
	6-10	0	0
	>10	31.6	30
Degree:	ADN	40	55
	BSN	50	45
	MSN	10	0
Years at Hosp:	0-1	30	20
	2-3	20	35
	4-5	20	15
	6-10	5	5
	>10	25	25
Emp status:	FT	90	90
	PT	5	20
	PRN	5	0
Floor:	Unit A	45	50
	Unit B	55	50
Shift:	Days	60	55
	Nights	40	45

The nurses were observed giving bedside shift report both pre and post educational intervention. Both shifts were observed for the critical behaviors required of bedside shift report (BSSR). Table 3 illustrates the observations as well as the percentage of the behaviors that were witnessed. Managing up the next staff member was one of the behaviors missed the most pre-educational intervention, as it was only completed 27% of the time. Another behavior missed was verifying the patient's goal for the shift, it was only completed 4% of the time. Bathroom needs were only addressed 15% of the time. This low percentage could be attributed to patients that were confused, sleeping, independent, or having foley catheters in place. Managing up staff greatly improved after the educational intervention as it improved from 27% to 85%. Verifying the patients goal

improved from 4% to 62%. Bathroom needs improved from 15% to 42%. The observations were analyzed using a chi-square test and the behaviors that showed a statistically significant change were managing up staff, verifying patient goal, asking if the patient had questions, pain assessment, bathroom needs, informing when the nurse would return, and thank the patient. All these metrics showed improvement in the numbers when looking at observations completed pre and post education. Any of these metrics that were missed in the post education observations, were addressed, and given real time education.

Table 3: Bedside Report Observations and Percentage of Behaviors Witnessed

Component	Pre # observed n=26	%	Post # observed n=26	%	Chi Square Result	p value
AIDET	20	77	24	92	2.54	0.11
Explain BSSR	19	73	23	88	1.18	0.28
Manage Up	7	27	22	85	15.91	<0.01
Include pt.	23	88	22	85	0.50	0.48
Check IV	15	58	19	73	0.62	0.43
Update White Board	22	85	26	100	2.12	0.15
Verify pt. goal	1	4	16	62	18.6	<0.01
Ask if pt. has questions	13	50	23	88	7.5	<0.01
Pain assessment	10	38	23	88	12.31	<0.01
Bathroom needs	4	15	11	42	4.20	0.04
Items in reach	17	65	17	65	0.03	0.86
Inform when return	17	65	24	92	4.18	0.04
Patient need anything	17	65	22	85	1.77	0.18
Thank you	8	30	23	88	16.15	<0.01

The target goal with the observations was for the critical behaviors to be completed 80% of the time. While most behaviors hit this target goal, there are some behaviors that still need improvement. For example, verifying the patients goal started off

only being observed 4% of the time and increased to 62% of the time, while this was a statistically significant change, it is still below the target range. Another behavior that this occurred with was bathroom needs. Before educational interventions, bathroom needs were assessed 15% of the time and after they were assessed 42% of the time. Again, while this was a statistically significant change, it was still far below the target goal for observed critical behaviors.

There are two questions from the survey that have statistically significant results. The questions that addressed job satisfaction and patient satisfaction both had statistically significant results, the mean for both questions increased in the survey that was administered after education was administered to the nurses. The mean for the question satisfied with last report received dropped during the second survey administered. Reasons for the drop in the mean could be attributed to changes in management, staffing changes, and an increase in hospital census. Table 4 illustrates the results of the survey analysis. The questions from the survey were analyzed using a two tailed t-test.

Table 4: Analysis of survey questions

	Pre-Mean	Post Mean	p value
Received BSSR last shift	1.05	1.05	0.97
Gave BSSR last shift	1.05	1.05	0.97
Satisfied with last report received	2.75	2.67	0.73
Satisfied with last report given	2.30	2.67	0.16
Relationship with patient affects job satisfaction	1.6	2.34	0.02
Patient satisfaction is related to relationship nurse has with pt./family	1.6	2.00	0.08
Enough time for report	2.40	2.37	0.92

Discussion

Prior to beginning this project, the nurses were using bedside shift report inconsistently. In the initial observations, it was noticed they were giving report outside the door, not including the patient, or omitting some of the critical behaviors. With the observation data, most of the components of report improved post intervention. During the post-observation when a component was not included, education was completed in the moment. The in the moment education was readily accepted by the nurses.

Nearly all the HCAHPS scores increased by the end of the project. The hospital still has scores below the 50th percentile, but the scores are improved from where they started in 3rd quarter 2020. Unit A has increased HCAHPS scores in all areas, with all of them being over the 50th percentile, some are over the 75th percentile, and one score over the 90th percentile. Unit B has increased scores in most areas, with most above the 50th percentile. These are great improvements for these two units as these units were chosen for their low HCAHPS scores.

In the real time observations that were completed, all the critical behaviors being observed increased in compliance. There was not a reduction in compliance observed. A few of the critical behaviors had a great increase in compliance. Although some of the critical behaviors improved and had statistically significant results, some of those still are below the target range of 80%. For instance, checking the patients IV went from 58 to 73%, this did not have a statistically significant result, but was still a substantial increase. This behavior did not make it to 80% but was close. Verifying the patient goal did have a statistically significant result but did not reach the target goal. The results changed from 4 to 62% showing a significant change in compliance, but not at the target goal yet.

Assessing bathroom needs did not reach the target goal, but this need also had a statistically significant result. The results increased from 15 to 42%, thus taking a big step in a forward direction but not where they need to be in terms of the goal. Managing up the next staff member took a big leap in the right direction changing from 17 to 85%. This behavior hit the target goal and was statistically significant.

During the observations conducted after the educational intervention, there were behaviors noted that were corrected with just in time education. These behaviors included, not addressing bathroom needs for patients with catheters in place, leaving out a pain assessment on a confused patient, and not trying to include a patient in the conversation that had decreased mental status.

Strengths and Limitations

The strengths of this project were that it took an in-depth look at the process the nurses were using for bedside report. The researcher was able to break down and look at each step of the bedside report process to see where education was needed the most. Using Lewin's model and the PDSA model, the staff was able to understand and implement change to their current process of report. This project ended in the changing phase of Lewin's model. The staff are still adapting to making bedside shift report a consistent part of their process. They have made several great improvements, but there is still room to improve.

With the PDSA cycle, we have moved into the act stage. Bedside shift report has been implemented and studied, but now we need to look at how we can improve the process that we have implemented.

Another strength was bedside report was already in use, so the nursing staff was familiar with the concept. Their process needed to be strengthened to fit the mold of true bedside shift report. This can be considered a strength and a weakness. It is a strength because they are familiar with the concept and do not need baseline education on how to complete bedside report, but yet a weakness because we need to get the staff away from bad habits in order to complete the process correctly.

One limitation to this project was the coronavirus pandemic, one important aspect of bedside shift report is including the family and/or significant others/friends in the bedside report process; as patients were not allowed visitors, or only allowed one, visitors were not in the patients rooms during shift change during the time of this project so that aspect was removed from observation. Another limitation that coronavirus contributed to is the fact that families may be the ones that fill out the HCAHPS surveys for patients. If the survey is filled out from the perspective of the family, that may be very different from the perspective of the patient.

Another limitation to this project is the current staffing crisis. The hospital is using a lot of contract staff for patient care. While contract staff may be dedicated to patient care, they may not be invested in making improvements to hospital processes as they are only there for a short time. Both units also experienced management changes during the same time frame that the project took place. When hospital staff are under stress, it may be very difficult for them to buy in to a new process. These two units did not have one stressor to contend with, but several: coronavirus, management change, contract staff, and a nursing staffing crisis.

Implications for Practice

The survey covered topics such as barriers to bedside report and general feelings regarding bedside report. Bedside shift report is an essential part of health care and keeping patients safe. Bedside shift report is a tool that can assist with patients getting engaged with their own care and gives the time to ask questions. For this to be successful, you must have buy in from the staff on the unit.

Based on the results of the survey, there is still education that needs to be completed to hardwire the importance of bedside shift report as very few nurses completed all required behaviors. A follow up survey with open ended questions may give new insight to what the nurses perceptions are regarding bedside report and the barriers they are facing.

Summary

This project demonstrated the needs for process change in a community hospital's bedside shift report. Healthcare is shifting and health care providers must change to meet the ever-changing demands and be proactive to protect patients. This project used AHRQ's toolkit as a plan to formulate a more effective way to give bedside report. The project supported conducting bedside shift report at the bedside with patient participation and input. Based on the outcome of this project, updated bedside shift report should be rolled out throughout the hospital using similar methods and tools.

Conclusion

The re-implementation of standardized bedside shift report was to increase compliance from the staff nurses as well as increase patient satisfaction scores. Although there were not many statistically significant outcomes from this project, the process can

be used going forward with increasing compliance. The nurses in this project were given a short time for education, with a longer education period, the outcomes may be better.

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Appendix A

Reference Matrix

CITATION Author(s), Date, Title, Journal Information, doi	PURPOSE / BACKGROUND Purpose & Outcome Measures or Goals (Aims)	PARTICIPANTS / SETTING Sample & Setting	METHODS / DESIGN Study Design & Interventions	RESULTS / LIMITATIONS / RECOMMENDATIONS Results, Strengths/Weaknesses, Limitations, & Recommendations
Agency for Healthcare Research and Quality (2013b). Nurse bedside shift report implementation handbook. Retrieved from: https://www.ahrq.gov/patient-safety/patient-families/engagingfamilies/strategy3/index.html	Handbook/information on how to implement AHRQ's perspective of bedside shift report.	Not research article	Can be applied to any nursing unit/hospital	
Ahmed, G. (2014). Kurt Lewin's change management model – a three step change	Descriptive article breaking down Lewin's Change management theory into its three phases.		After description, takes a deeper dive into the three stages with specific examples regarding organizational change.	
Anderson, J., Malone, L., Shanahan, K., & Manning, J. (2014). Nursing bedside clinical handover – an integrated review of issues and tools. <i>Journal of Clinical Nursing</i> , 24, 662-671.	Literature review looking at support for bedside report and then identify issues that contribute to poor compliance with bedside report.	Literature review	Database search of EBSCOhost, search terms were clinical, handover, bedside and nursing. The search produced 61 articles. After final review, 25 articles met criteria.	It was found that many clinicians felt the transfer of responsibility for patient care occurred at the end of the shift and not at bedside report. It was also mentioned in several articles that clinicians were concerned about confidentiality. It was noted that bedside handover does decrease end of shift overtime. The authors found

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				several different handover tools, but not one tool is suitable for all clinical areas.
Baker, S.J. (2010). Bedside shift report improves patient safety and nurse accountability. <i>Journal of Emergency Nursing</i> , 36(4), 355-358.	Explained how the use of bedside report can improve patient safety and staff accountability	Descriptive article	Oncoming nurse should review the chart and gather patient's history and any pending orders/treatments, etc. before starting report with off going nurse, then both nurses go to the bedside together to do a focused report with the patient	This offers opportunities for real time conversations. If nurses are in the room together, it enables the ongoing nurse the time to ask questions about things in the room, rather than having questions after the offing nurse has left the facility. This also provides a sense of trust and safety for the patients. BSR gives the opportunity to manage up the next staff member to the patient and hopefully ease any anxiety the patient may be feeling. BSR also encourages patient participation in their care. Patients are encouraged to participate in BSR.
Blouin, A.S. (2011). Improving hand off communications: new solutions for nurses. <i>Journal</i>	Looked at specific risk points and contributing factors that lead to barriers in hand off communication	Not research	Develop SHARE: S □ standardize critical content H □ hardwire within your system	Nurses are key stakeholders with bedside report. Nurses can participate in organization wide efforts through Targeted Solutions

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<i>of Nursing Care Quality</i> , 26(2), 97-100.			A □ allow opportunity to ask questions R □ reinforce quality and measurement E □ educate and coach	Tool which exemplified work of the Joint Commission.
Boshart, B.m Knowlton, M., & Whichello, R. (2016). Reimplementing bedside shift report at a community hospital. <i>Nursing Management</i> , 52-55.	Use a quality improvement process to re-introduce bedside shift report	294 bed community hospital in eastern North Carolina. Standard practice included nurse to nurse shift report at the nurse's station or in a conference room.	Identify why bedside report failed during the first implementation. Begin new initiative with education at department staff meetings. Round daily on all units to encourage staff members to adapt to the new process. After 60 days, validate competency.	3 months after re-implementation, random nursing checks were at 100% compliance. For future implementation, it was found that it would be better to stagger the units going live rather than everyone all at once.
Burnes, B. (2004). Kurt Lewin and the planned approach to change: a re-appraisal. <i>Journal of Management Studies</i> , 41(6), 977-1002.	Descriptive article of Lewin's background and believes, commitment to resolving social conflict.	Article examines Kurt Lewin's main elements of Change Theory.		Article compares major developments in the field of organizational change to Lewin's theory and finds that rather than being outdated, his theory is still relevant today.
Cairns, L.L., Dudjak, L.A., Hoffman, R.L., & Lorenz, H.L. (2013). Utilizing bedside shift report to improve the effectiveness of shift handoff. <i>The Journal of Nursing</i>	Evaluate effects of redesigning shift handoff report on effectiveness and efficiency measured by end of shift overtime, call light use, patient perception, and staff perception.	23 bed inpatient trauma unit in large tertiary academic hospital in southwest Pennsylvania.	PDSA model. Anonymous 7 question survey developed by investigator to determine satisfaction with current report structure and to gather specific concerns regarding bedside	Confirmed positive relationships between bedside shift report and end of shift overtime, call light usage, and satisfaction. Showed a reduction in overtime by 61 hours per

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<i>Administration</i> , 43(3), 160-165.			report. Mandatory education was instituted after survey completion. Education was delivered via power point, handouts, and role play. One month after initiation, the nurses were sent another survey to evaluate satisfaction in addition to asking questions about new focus vs old focus. Three months post implementation the nurses were survey again.	year. Bedside report was shorter than traditional report and did not interfere with ability to complete tasks on time.
Carlson, S.A. (2013). Make it a habit: 2 weeks to bedside report. <i>Nursing Management</i> , 52-54	QI project to heighten awareness of how important bedside report is and how it benefits patients.	36 bed vascular surgery/medical progressive care unit in a Midwestern hospital	Educational plan regarding bedside report was put in place as well as developing a standardized bedside tool was created. The bedside report tools were turned in over a two-week period.	344 bedside report tools were turned in over the two-week period. 86.9% of the nurses completed the tool. 20 nurses also responded to an evaluation questionnaire. Of those responses, 80% stated that they used the report tool, and 70% stated it helped make bedside report a habit.
Cornell, P., Gervis, M.T., Yates, L., & Vardaman, J.M. (2014). Impact of SBAR on nurse shift reports and staff	Looked at impact of SBAR and interdisciplinary rounds on shift report using process measure such as report time,	48 bed medical surgical unit in a suburban hospital in the mid-south, 36 clinical care	Nurse workflow was observed via interview, survey, sampling, and direct observation.	16 shift reports were observed for baseline, 19 for SBAR, 16 several weeks later. Time to complete

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rounding. <i>MEDSURG</i> , 23(5), 334-342.	quality of information, use of paper, transcription time, patient review time.	nurses participated in multiple observations	Observers recorded: nurse tasks, tools, collaborators, and location. The nurse being observed was selected randomly. The first observation was completed with the nurse using existing methods for report. The second method the nurse used the SBAR method. The third observation was performed several weeks after training.	report decreased from 53 minutes to 38 minutes. It was noted that patient conditions and action plans were more of a focus during report rather than just information recording. An implication for further practice would be to expand this method to other units to compare results.
Faloon, D.N., Hampe, H., & Cline, T. (2018). Effects of multimethod intervention on bedside report compliance and patient satisfaction. <i>Critical Care Nursing Quarterly</i> , 41(2), 129-141.	Evaluate the effectiveness of education on nurse compliance with bedside shift report in an inpatient stroke telemetry unit.	This study took place at Allegheny General Hospital. This is a 631 bed, urban teaching hospital in Pittsburgh, PA. The study was completed on a 43-bed inpatient stroke unit.	The intervention was education via video, written handout, peer to peer demonstration, and verbal education. The video was run for two weeks and the RN's had to sign off that they viewed it. The RN's were also given one on one education of how bedside shift report should look. RN's were given surveys prior to the intervention to assess baseline knowledge of bedside report. They were surveyed again three-	It was found that bedside report increased to 81% percent by the 6-month survey. It was also found that introductions increased to 100% by six months. One limitation is this data only pertains to one unit and not the hospital. It was also noted that this unit experienced high turnover during the study, thus many of the nurses present at 6 months were not present at the start of the study.

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			and six-months post implementation.	
Gregory, S., Tan, D., & Tilrico, M. (2014). Bedside shift reports: What does the evidence say? <i>Journal of Nursing Administration</i> , 44(10), 541-545.	This was a literature review of bedside shift report and the effect on improving quality of care, safety, and patient centered care.	A computer assisted literature search yielded 33 studies meeting inclusion criteria including data specific to nurses and bedside shift report.	Systematic literature review	Even though literature supports bedside shift report, issues were still identified regarding sustaining the process after implementation. Many studies made the recommendation of evaluating nurses' attitudes pre and post intervention to identify if interventions were necessary to sustain the practice change.
Griffin, T. (2010). Bringing change of shift report to the bedside: A patient and family centered approach. <i>Journal of Perinatal and Neonatal Nursing</i> , 24(4), 348-353.	Article describing bedside shift report, its meaning and process. The authors also spoke to the need for change regarding bedside shift report. Bedside shift report leads to decreased errors and increased patient safety.		The author discussed the challenges to bring report to the bedside as well as the benefits.	The goal of bedside report and patient and family centered care is to maximize patient safety and the overall care experience. The patient, family, and nurse should work as a partnership.
HCAHPS (2019). HCAHPS Fact Sheet. Retrieved from: https://www.hcahponline.org/	Fact sheet regarding HCAHPS survey	Not a research article	Describes what HCAHPS is, who received survey, what survey measures	

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globalassets/hcahps/facts/hcahps_fact_sheet_march_2021.pdf				
Holly, C., & Poletick, E.B. (2013). A systematic review on the transfer of information during nurse transitions in care. <i>Journal of Clinical Nursing</i> , 23, 2387-2396.	Looked at how to determine what information to give during transfer of care between nursing shifts and what factors influenced the type of information chosen to share.	Final sample yielded 29 qualitative studies that represented over 800 nursing handoffs and 300 nurse interviews – only literature that was included described what and how information got transcribed during handoff report.	Literature review of qualitative studies that looked at process of nurse-nurse report and what and how information was transferred. Literature search was completed on MEDLINE and CINAHL using keywords. Review findings were pooled together and categorized by likeness in meaning.	125 articles were identified. A total of 29 studies were chosen for inclusion. 117 findings were identified and grouped into 16 categories. They found that nurses influence patient care as the gatekeeper of the information that is handed off. Approximately 70% of the data conveyed in end of shift report had a documentation source.
Jeffs, L., Acott, A., Simpson, E., Campbell, H., Irwin, T., Lo, J., Beswick, S., & Cardoso, R. (2013). The value of bedside shift reporting: Enhancing nurse surveillance, accountability, and patient safety. <i>Journal of Nursing Care Quality</i> , 28(3), 226-232.	Qualitative study looked at the experiences and perceptions of nurses as bedside shift report was implemented.	This study was conducted in an inner-city acute care teaching hospital. The units included had already implemented bedside shift report.	An initial recruitment email was sent to the nursing staff. For all nurses that were interested in participating, interviews were scheduled at convenient times for them. The interviews asked questions regarding perceptions and experiences associated with implementation of bedside	A total of 43 interviews were conducted. Nurses identified that through bedside report they were able to clarify information relating to the care and needs of patients. They identified that they were able to identify errors in care. The opportunity for patients to ask questions was perceived in a positive light by the nurses. The nurses

CITATION Author(s), Date, Title, Journal Information, doi	PURPOSE / BACKGROUND Purpose & Outcome Measures or Goals (Aims)	PARTICIPANTS / SETTING Sample & Setting	METHODS / DESIGN Study Design & Interventions	RESULTS / LIMITATIONS / RECOMMENDATIONS Results, Strengths/Weaknesses, Limitations, & Recommendations
			report. The interviews were conducted 6 months following initial *implementation.	were able to conduct a quick initial assessment on their patients, which was viewed as a more accurate method of exchanging information on the status of a patient. One limitation of the study was that it was only conducted at one hospital, limiting its generalizability. Many responses in this study were positive but may not be the same for other settings in health care.
The Joint Commission (2017, September 12). Sentinel alert event: Inadequate Hand-Off communication. Retrieved from: https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_58_hand_off_comms_9_6_17_final_(1).pdf	Joint commission statement regarding dangers of inadequate hand offs	Not research article	Speaks to the dangers of inadequate handoff communication in health care and offers suggestions on how to improve	
Juneia, P. (2015). Kurt Lewin's change management model: The planned approach	Article describing Lewin's change model	Not research article	Takes step by step explanation of Lewin's change model	

CITATION Author(s), Date, Title, Journal Information, doi	PURPOSE / BACKGROUND Purpose & Outcome Measures or Goals (Aims)	PARTICIPANTS / SETTING Sample & Setting	METHODS / DESIGN Study Design & Interventions	RESULTS / LIMITATIONS / RECOMMENDATIONS Results, Strengths/Weaknesses, Limitations, & Recommendations
to organizational change. Retrieved from: https://www.managementstudyguide.com/kurt-lewins-change-management-model.htm				
Mardis, T., Mardis, M., Davis, J., Justice, E., Holdinsky, S., Donnelly, J., Ragozine-Bush, H., & Riesenber, L. (2016). Bedside shift-to-shift handoffs: A systematic review of the literature. <i>Journal of Nursing Care Quality</i> , 31(1), 54-60.	This is a systematic review of literature looking at the impact of bedside report on patients as well as providers.	Literature search of English language articles published regarding bedside handoff between January 1, 2008 and October 31, 2014.	Articles included focused on shift to shift handoff, had qualitative/quantitative research data, and focused on bedside handoff. Article excluded included not handoff specific, focused on inter/intra hospital transfer, no data, or letters to the editor/commentary/newsletter articles. 41 relevant articles were chosen for review.	Multiple studies reported increased patient and nurse satisfaction when bedside report was used. Only 6 articles were found to use patient outcome metrics to evaluate handoff, none of which reported statistically significant results. Some of the articles reported that nurses were concerned about the time it took to give bedside report, medical jargon used during conversation, patient confidentiality. None of the studies mentioned concerns regarding confidentiality that were serious enough to warrant not implementing the process. Limitations

CITATION Author(s), Date, Title, Journal Information, doi	PURPOSE / BACKGROUND Purpose & Outcome Measures or Goals (Aims)	PARTICIPANTS / SETTING Sample & Setting	METHODS / DESIGN Study Design & Interventions	RESULTS / LIMITATIONS / RECOMMENDATIONS Results, Strengths/Weaknesses, Limitations, & Recommendations
				include that the study was limited to English only articles. Another limitation is that studies with negative outcomes may not be published.
McMurray, A., Chaboyer, W., Wallis, M., & Fetherston, C. (2010). Implementing bedside handover: strategies for change management. <i>Journal of Clinical Nursing, 19</i> , 2580-2589.	Study that looked at the change from taped to bedside report.	Study was conducted in two regional acute care hospitals in Queensland, Australia; both hospitals had implemented bedside report as part of a safety initiative.	532 semi structured observations in 6 wards and 34 interviews were conducted. Observations were equivalent at both hospitals. The interviews addressed structure and process of communicating patient information during bedside report.	Both hospitals reported patient reactions to bedside report were positive. Involving the patient during handoff was found to be more comprehensive and purposeful.
Novak, K., & Fairchild, R. (2012). Bedside reporting and SBAR: Improving patient communication. <i>Journal of Pediatric Nursing, 27</i> , 760-762.	This article looked at current evidence to determine if bedside report utilizing SBAR provided enhanced outcomes on pediatric units when compared with traditional report given outside the patient's room utilizing the report format of the nurse's choice.		During the literature review, the researchers found variation in handover methods related to duration, location, and information being exchanged. It was shown that verbal handovers can be very lengthy and include non-essential information.	They found that evidence suggested that bedside report gave the oncoming nurse time to ask questions as well as direct observation of the patient. Literature also showed that bedside report increased patient and family satisfaction. Changes in patient status can be quickly identified during bedside report. One obstacle to instituting this is that units

CITATION Author(s), Date, Title, Journal Information, doi	PURPOSE / BACKGROUND Purpose & Outcome Measures or Goals (Aims)	PARTICIPANTS / SETTING Sample & Setting	METHODS / DESIGN Study Design & Interventions	RESULTS / LIMITATIONS / RECOMMENDATIONS Results, Strengths/Weaknesses, Limitations, & Recommendations
				must have a process to follow when patients are asleep during report. Nurses also must be aware of sensitive information being exchanged during report.
Radtke, K. (2013). Improving patient satisfaction with nursing communication using bedside shift report. <i>Clinical Nurse Specialist</i> , 19-25.	Study to look at if standardizing bedside shift report improved patient satisfaction with nursing communication.	Pilot program for a 16-bed med surg intermediate care facility in a 320-bed tertiary care facility.	Looked at post discharge satisfaction surveys prior to implementation of pilot program. The program was to standardize bedside shift report to improve satisfaction. Patient satisfaction was monitored for three months post implementation.	Patient satisfaction was at 87.6% post implementation, an increase from 75% 6 months prior. This practice change was monitored for compliance. The patient satisfaction score did not reach the goal of 90%, but it did show that bedside report does impact patient satisfaction.
Rogers, J., Li, R., Clements, R., Caserperson, S., & Sifri, C. (2017). Can we talk? The bedside report project. <i>Critical Care Nurse</i> , 37(2), 104-107.	Improve communication between nurses through implementation of standardized bedside shift report	Catholic Health Initiatives Franciscan Health System's Regional Hospital – 26 bed long term acute care facility.	Computer based survey created to assess current attitudes of nurses regarding shift report and their expectations and thoughts regarding moving shift report to the bedside.	Medication errors related to hand off reduced 80%. Patient falls related to handoff reduced 100%. They also noted a 12% in family satisfaction and a 23% increase in patient satisfaction.
Scheidenhelm, S., & Reitz, O. (2017). Hardwiring bedside shift report. <i>The Journal of</i>	Increase compliance with nurse bedside report and in turn increase patient satisfaction scores	149 bed community hospital, 46 bed med surg unit and 12 bed OB unit	Quasi experimental design with pre-implementation and post-implementation comparison of patient	Pre-implementation, 197 patients returned surveys on the med surg unit, 93 returned for the OB unit.

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<p><i>Nursing Administration</i>, 47(3), 147-153.</p>			<p>satisfaction scores from 2 returned surveys. Nurses viewed simulated bedside report plus were given electronic learning.</p>	<p>Post-implementation, 190 patients returned surveys for med surg and 99 for OB. The nurse's compliance with bedside report went from 12% on med surg to 85% and from 55% on OB to 90.6%. A limitation of this study is that it was conducted on two units at a community hospital, it would need to be conducted at multiple hospitals on multiple units to see if the interventions truly made a difference.</p>
<p>Tobiano, G., Bucknall, T., Sladdin, I., Whitty, J.A., & Chaboyer, W. (2018). Patient participation in nursing bedside handover: a systematic mixed methods review. <i>International Journal of Nursing Studies</i>, 77, 243-258.</p>	<p>Explore the role of the patient in bedside report as well as looking at the barriers and enhancing the process</p>		<p>Mixed methods review. Literature search performed. Papers were screened against inclusion/exclusion criteria and then classified as research or QI projects. Only papers classified as research or QI were used. Patients and nurse perceptions were analyzed separately.</p>	<p>21 research studies included, and 25 QI projects included. It was found that patients wanted to participate in handover because it made them feel part of the process. Patients did suggest that nurses stand closer to the patients rather than further away. Nurses felt patient participation could improve communication. Awareness of patient preferences helped enable participation.</p>

CITATION Author(s), Date, Title, Journal Information, doi	PURPOSE / BACKGROUND Purpose & Outcome Measures or Goals (Aims)	PARTICIPANTS / SETTING Sample & Setting	METHODS / DESIGN Study Design & Interventions	RESULTS / LIMITATIONS / RECOMMENDATIONS Results, Strengths/Weaknesses, Limitations, & Recommendations
Vines, M.M., Dupler, A.E., Van Son, C.R., & Guido, G.W. (2014). Improving client and nurse satisfaction through the utilization of bedside report. <i>Journal for Nurses in Professional Development</i> , 30(4), 166-173	Does bedside report promote patient and nurse satisfaction		Literature review via CINAHL – 95 publications retrieved – narrowed down to 9 after limited by date/setting/population/relevance	Higher HCAHPS scores correlated with higher satisfaction with communication between patient and caregiver. Bedside report increased patient satisfaction by keeping patients informed, staff working together, patients being included regarding decisions. Nurses felt less communication errors were created with bedside report. Nurse satisfaction increased from 37% to 78% in one article reviewed.
Wakefield, D.S., Ragan, R., Brandt, J., & Trenago, M. (2012). Making the transition to nursing bedside shift reports. <i>The Joint Commission Journal on Quality and Patient Safety</i> , 38(6), 243-253.	This article looked at one unit's transition from traditional end of shift report to bedside end of shift report.	The study took place in an academic hospital in the Midwest. The unit chosen was a med-surg unit, not monitored by an intensivist, with 20 staffed beds.	Survey data was collected from the nurse's pre and post implementation. The data that was collected included report process, perceptions about report process, issues they felt difficult to address at the bedside. The nurses were given a data sheet with the steps of handoff report and asked to record how much	For the first 6 months post implementation, patient satisfaction scores increased by an average of 11 points. For the 23 month follow up period, the increase averaged out to an increase of 6.9 points. The nurses agreed overall that bedside report was a better way to handoff patients. It was found that not all nurses received this

CITATION Author(s), Date, Title, Journal Information, doi	PURPOSE / BACKGROUND Purpose & Outcome Measures or Goals (Aims)	PARTICIPANTS / SETTING Sample & Setting	METHODS / DESIGN Study Design & Interventions	RESULTS / LIMITATIONS / RECOMMENDATIONS Results, Strengths/Weaknesses, Limitations, & Recommendations
			time it took to complete each step.	project well and at the 23-month evaluation mark, some nurses had converted back to the old way of giving report. A limitation of this study is that it was only conducted on one unit.
Wojciechowski, E., Pearsall, T., Murphy, P., & French, E. (2016). A case review: Integrating Lewin's theory with lean's system approach for change. <i>The Online Journal of Issues in Nursing, 21</i> (2),	Discuss collaboration used for problem solving, specifically to create interventions for bedside report.	182 bed acute inpatient rehab facility in large Midwest city.	They used Lewin's three step model for change. This model includes unfreezing, changing/moving, and refreezing. They also used the lean system method of Plan-Do-Study-Act.	One outcome reached was an enriched process of collaboration. A second outcome, which was the big one they were striving for, was an intervention model of bedside shift report.
Zou, X., & Zhang, Y. (2016). Rates of nursing errors and handoffs related errors in a medical unit following implementation of a standardized nursing handoff form. <i>Journal of Nursing Care Quality, 31</i> (1), 61-67.	Study to look at the effectiveness of using a standardized form for handoff	This study was conducted in a medical unit at a general hospital in China. The unit had 80 beds, 45 nurses working day and night shifts.	This was a prospective intervention study. The study used a pretest-protest design. Preintervention data was collected for 10 months. For the next 10 months, the intervention was applied. After the intervention period, post intervention data was collected. All nurses on the unit received training on handoff practices and were asked to use the new form.	Total nursing errors pre and post intervention decreased from 180 to 112. Handoff related errors decreased from 53 to 5 post implementation. Non handoff related errors decreased from 127 to 107 post implementation. The reduction in total nursing errors and handoff related errors were both significant. The authors stated that it is unclear how generalizable these results are. They also

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			The incidence of errors per 100 admissions was measured pre and post intervention.	state that nurse's experience over time and difference in patient population may make a difference in errors.

Appendix B

Pre-Implementation Survey Email

Your nursing unit has been selected to participate in a bedside report survey. This survey will be analyzed by myself as part of my DNP scholarly project. The purpose of this survey is to determine the barriers nurses are currently facing when it comes to completing bedside shift report.

Your participation in this survey is voluntary, there is no penalty for choosing not to participate. If you choose to participate, please complete the survey online via survey monkey. Completing the online survey implies consent to participate in the study.

All survey responses will remain anonymous. The responses gathered will help evaluate the current hand off process and make improvements going forward.

Any questions or concerns, please contact me.

Lisa Randall

Appendix C
Post Implementation Email

Thank you for your participation in the bedside report project. This project consisted of a pre-implementation survey, observations of your report technique, implementation of education, and now a post implementation survey. Your participation and honest feedback enables us to provide the safest care possible for our patients.

Once all surveys are collected and all data is analyzed, results of this project will be made available to you. I realize that participating in the survey took time and I value the time that you committed towards helping with this research project. As with the first survey, the results from this survey are completely anonymous. Feel free to provide any comments you deem necessary or relevant to improve this project.

Your response and time are greatly appreciated.

Thank you.

Lisa Randall, MSN, RN, CCRN-K

Appendix D

Bedside Report Pre-Implementation Survey

1. How many years have you been a nurse?

- 0-1 year
- 2-3 years
- 4-5 years
- 6-10 years
- > 10 years

2. What is your nursing degree level?

- ADN
- BSN
- MSN
- other

3. How long have you worked at Christian Hospital?

- 0-1 year
- 2-3 years
- 4-5 years
- 6-10 years
- >10 years

4. What is your employment status?

- Full Time
- Part Time
- PRN
- Agency Nurse

5. What floor do you work on?

- 6th Floor
- 10th Floor

6. What shift do you normally work?

- Days
- Nights

7 On average, how long does report generally take (please list in minutes)?

8 Did you receive bedside report (in the patient's room) on the last shift you worked?

- Yes
- No

9 Did you give bedside report (in the patient's room) on the last shift you worked?

Yes

No

10. Do you use any type of tool to aid in patient report?

I do not use a tool

I use a form I created myself

I use a checklist

other _____

11. How satisfied are you with the report you received on the last shift you worked?

Extremely satisfied

Very Satisfied

Satisfied

Somewhat dissatisfied

Extremely dissatisfied

12. How satisfied are you with the report you gave on the last shift you worked?

- Extremely satisfied
- Very Satisfied
- Satisfied
- Somewhat dissatisfied
- Extremely dissatisfied

13. To what degree do you think your relationship with the patient/family affects your job satisfaction?

- Not at all
- A little
- Some
- A Lot
- Extremely

14. To what degree do you think patient satisfaction is related to the relationship the patient/family develops with the nurse?

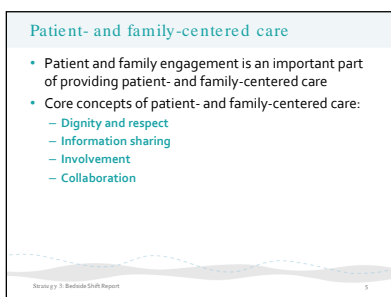
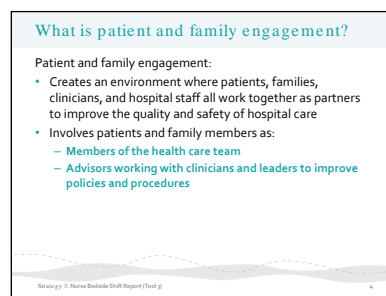
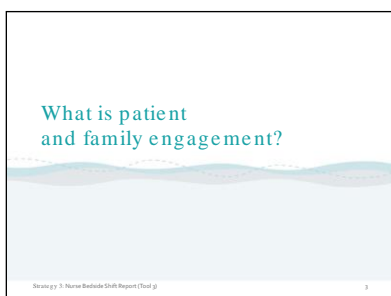
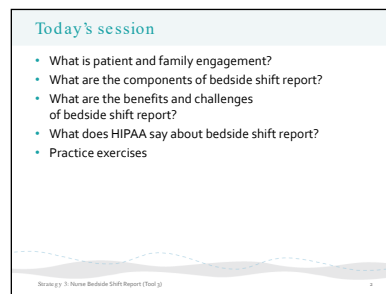
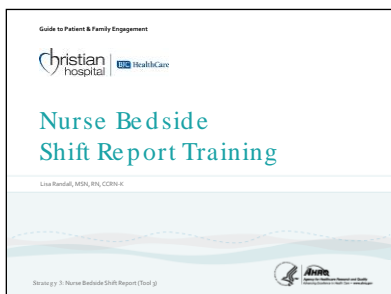
- Not at all
- A little
- Some
- A Lot
- Extremely

15. I feel that I have enough time to give and receive report.

- Strongly Agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly Disagree

16. Is there anything else you would like to add about your current experience with bedside report?

Appendix E



Why focus on bedside shift report?

- Transitions in care have potential for medical errors
- Research shows bedside shift report can improve:
 - Patient safety and quality
 - Improved communication
 - Decrease in hospital-acquired complications
 - Patient experiences of care
 - Time management and accountability between nurses
 - Decrease in time needed for shift report
 - Decrease in over time

Strategic 3: Nurse Bedside Shift Report (Total 6)

7

What is the patient and family experience at our hospital?

Strategic 3: Nurse Bedside Shift Report (Total 6)

8

What is it like being a patient?

Clinicians and hospital staff	Patients and family
<ul style="list-style-type: none"> • Know how the hospital works and how to get things done 	<ul style="list-style-type: none"> • Are strangers in this environment • Do not understand the system or culture • Know about their body and life situation better than hospital staff
<ul style="list-style-type: none"> • Know who hospital staff are and what they do 	<ul style="list-style-type: none"> • Do not know who different staff are and what they do • May want family or friends to support them • May feel nursing staff are unavailable for multiple hours during shift change
<ul style="list-style-type: none"> • Are busy and under a lot of stress 	<ul style="list-style-type: none"> • Are often in pain or uncomfortable, vulnerable, or afraid • Are worried and want to do what they can for the patient (family members) • Are aware that hospital staff are busy and may not want to bother you
<ul style="list-style-type: none"> • Want to provide high-quality and safe care 	<ul style="list-style-type: none"> • Trust hospital staff to provide safe and quality care

Strategic 3: Nurse Bedside Shift Report (Total 6)

9

Bedside shift report

- Critical elements
- Benefits
- Challenges

Strategic 3: Nurse Bedside Shift Report (Total 6)

10

What is bedside shift report?

- Nursing staff conducts shift change reports at the patient's bedside
- Patient can identify a family member or close friend to participate
- Report should take about 5 minutes per patient
- Purpose:
 - To engage the patient and family in hospital care
 - To share accurate and useful information between nurses, patients, and families

Strategic 3: Nurse Bedside Shift Report (Total 6)

11

Critical elements of bedside shift report

- Introduce the nursing staff, patient, and family.
- Invite the patient and family to participate
- Open medical record or electronic work station in the patient's room
- Conduct a verbal SBAR report with the patient and family, using words they can understand
- Conduct a focused assessment of the patient and a safety assessment of the room
- Review tasks that need to be done
- Identify needs and concerns of the patient and family

Strategic 3: Nurse Bedside Shift Report (Total 6)

12

Benefits of bedside shift report for patients

- Acknowledges patients as partners
 - "You do get the feeling of at least being wanted. You're not just a patient in the bed."
 - "It makes you feel like you're involved."
- Builds trust in the care process
 - Shows the patient how much nurses know and do for them
 - Shows teamwork among the nursing staff, reassuring the patient that everyone knows what is going on with them

Strategic 3: Nurse Bedside Shift Report (Total 6)

13

Benefits of bedside shift report for patients (continued)

- Encourages patient and family engagement
 - Gives the patient and family an opportunity to ask questions and correct any inaccuracies in handoff
 - Informs the patient and family members about the patient's care throughout the stay and helps with the transition to home

Strategic 3: Bedside Shift Report

14

Benefits of bedside shift report for nurses

- Better information about the patient's condition
- Accountability
- Time management
- Patient safety

Strategy 3: Nurse Bedside Shift Report (Tool 1)

15

Video of bedside shift report



Strategy 3: Nurse Bedside Shift Report (Tool 1)

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Tips for bedside shift report

- Invite patients and family at admission to participate using bedside shift report brochure (Tool 1)
- Use checklist to facilitate bedside shift report (Tool 2)
- Don't address a problem with the room or situation outgoing nurse in front of the patient
- Thank the nurse going off duty if everything is in good shape

Strategy 3: Nurse Bedside Shift Report (Tool 1)

17

Potential challenges

- Unknown visitors or family in the room
- New diagnosis or information patient is not yet aware of (e.g., waiting for doctor to discuss)
- Patient is asleep
- Patient is noncompliant and you need to share information with oncoming nurse
- Patient or family has a complex question or needs a lengthy clarification
- Semi-private rooms and HIPAA concerns

Strategy 3: Nurse Bedside Shift Report (Tool 1)

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HIPAA and Bedside Shift Report

Adapted from Emory University Bedside Shift Report Bundle Training

Strategy 3: Nurse Bedside Shift Report (Tool 1)

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Addressing HIPAA concerns

- Health information can be disclosed for:
 - Treatment
 - Health care operations
 - Payment
- HIPAA acknowledges incidental disclosures may occur
- Not a HIPAA violation as long as
 - Take reasonable safeguards to protect privacy
 - Disclose only or use the minimum necessary information

Strategy 3: Nurse Bedside Shift Report (Tool 1)

20

Addressing HIPAA concerns (continued)

- Is a covered entity required to prevent any incidental use or disclosure of protected health information?
- Answer: No. The HIPAA Privacy Rule does not require that all risk of incidental use or disclosure be eliminated to satisfy its standards. Rather, the rule requires only that covered entities implement reasonable safeguards to limit incidental uses or disclosures. See 45 CFR 164.530(c)(2).

Strategy 3: Nurse Bedside Shift Report (Tool 3)

21

Addressing HIPAA concerns (continued 2)

- Can physicians and nurses engage in confidential conversations with other providers or with patients, even if there is a possibility that they could be overheard?
- Answer: Yes. HIPAA does not prohibit providers from talking to each other and to their patients. Providers' primary consideration is the appropriate treatment of their patients.

Strategy 3: Nurse Bedside Shift Report (Tool 3)

22

Addressing HIPAA concerns (continued 3)

- Oral communications often must occur freely and quickly. Covered entities are free to engage in communications as required for quick, effective, and high-quality health care. For example:
 - Coordinate services at nursing stations
 - Discuss a patient's condition or treatment regimen in the patient's semiprivate room
 - Discuss a patient's condition during training rounds in an academic or training institution

Strategy 3: Nurse Bedside Shift Report (Tool 3)

23

Final thoughts

- Our hospital is committed to patient and family engagement — everyone plays a critical part
- Patients and families won't engage if they believe that you don't want them to—it is simply too risky for them
- Your job is to make it safe for them to be involved, not just as patients but as partners in their care

Strategy 3: Nurse Bedside Shift Report (Tool 3)

24

Thank you

- For questions or more information
 - Lisa Randall
 - 314-653-5802
 - Lisa.Randall@bjc.org

Strategy 3: Nurse Bedside Shift Report (Tool 3)

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Appendix F
Bedside Report Observation Tool

Date _____ Department _____ Shift _____

Introductions:	Observed (Y/N)	Comments
Knock on door prior to entering		
AIDET		
Explain bedside report		
Manage up oncoming staff		
Safety:		
Bring patient into conversation		
Check IV site, solution, tubing		
Informed		
Update white board		
Verify patient goal for shift		
Ask if patient has questions		
Address 3 P's		
Pain assessment		
Bathroom needs		
Assess Environment		
Move items within reach		
Closing		
Inform next round		
Anything else they need		
Thank you		

Appendix G
Bedside Report Post Implementation Survey

1. How long have you been a nurse?

- 0-1 year
- 2-3 years
- 4-5 years
- 6-10 years
- >10 years

2. What nursing degree do you hold?

- ADN
- BSN
- MSN

3. How long have you worked at Christian Hospital?

- 0-1 year
- 2-3 years
- 4-5 years
- 6-10 years
- >10 years

4. What is your employment status?

Full Time

Part Time

PRN

agency

5. Which floor do you work on?

6th Floor

10th Floor

6. What shift do you normally work?

Days

Nights

7. On average, how long does bedside report generally take (please list in minutes)?

8. Did you receive bedside report on the last shift you worked?

yes

no

comments _____

9. If you answered no to the previous question, can you explain why?

10. Did you give bedside report on the last shift you worked?

yes

no

comments _____

11. If you answered no to the previous question, can you explain why?

12. How satisfied are you with the report you received on the last shift you worked?

Extremely satisfied

very satisfied

satisfied

somewhat satisfied

not at all

13. How satisfied are you with the report you gave on the last shift you worked?

Extremely satisfied

very satisfied

satisfied

somewhat satisfied

not at all

14. To what degree do you think your relationship with the patient/family affects your job satisfaction?

- extremely
- a lot
- some
- a little
- not at all

15. To what degree do you think patient satisfaction is related to the relationship the patient/family develops with the nurse?

- extremely
- a lot
- some
- a little
- not at all

16. When receiving report, is it presented in an organized manner?

- yes
- no
- comments _____

17. How would you describe the accuracy of the report you received on the last shift you worked?

- extremely accurate
- very accurate
- accurate
- somewhat accurate
- not at all accurate

18. I feel I have enough time to give/receive report.

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

19. Other comments regarding bedside shift report?
