IMPROVING COMMUNICATION IN THE CLINICAL ENVIRONMENT THROUGH

BEDSIDE SHIFT REPORT (BSR): A QUALITY IMPROVEMENT PROJECT

by

Karen Burk

MARYLEE BRESSIE, DNP, Faculty Mentor and Chair

JOHN SCHMIDT, DNP, Committee Member

ANITA GRIMES, MSN, Committee Member

Patrick Robinson, PhD, Dean, School of Nursing and Health Sciences

A DNP Project Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Nursing Practice

For submission to the *American Journal of Nursing*

Capella University

August 2016

Abstract

Effective communication is required during the handoff process to ensure essential patient information is relayed for continuity and quality of care. The author conducted a quality improvement initiative at a 380 bed acute care facility using Lewin's Change Theory and implementing a structured tool to standardize handoff practice at the bedside that included the patient (bedside shift report [BSR]). Outcomes were measured for patient and nursing satisfaction and a decrease in medication errors over a four-week period of time. Results show that BSR improved patient satisfaction scores in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores and the potential for improving medication errors by including the patient and having both nurses review the medications as part of the implemented structured tool.

Keywords: handoff, nursing, medication errors, communication, patient satisfaction.

Quality Improvement Project

With the changing health care system, *ineffective* communication is under scrutiny. Insurance companies and the government are listening to patient feedback on how effectively nurses and physicians communicate during hospital stays. Ineffective communication can influence reimbursement to healthcare facilities and possibly the percentage of provider fees (Long, 2012). With the establishment of the National Quality Strategy (NQS) policy, the U.S. Department of Health and Human Services (2013) mandated effective communication as one of six priorities to address the need for quality improvement in the United States, and the Joint Commission (TJC, 2014) identified effective communication as a Hospital National Patient Safety Goal. According to research, 70% of sentinel events are related to some type of breakdown in communication (Adams & Osborne-McKenzie, 2012).

Of these, an alarming 50% can be traced back to communication breakdown during the process of patient handoff (Adams & Osborne-McKenzie, 2012). Handoff (also called handover or change of shift report) can be defined as the transfer of patient care that includes transferring "information, responsibility, and authority between clinicians" (Abraham, Kannampallil, & Patel, 2014, p. 154). Handoff requires effective communication to ensure essential patient information is relayed for continuity and quality of care (Griffin, 2010).

During clinical rotations with nursing students, the researcher observed a problem with nursing handoff practice on a medical-surgical floor at a local, Pennsylvania trauma center. Nurses were assigned patient workloads depending on odd or even numbered rooms and listened to tape recorded report in two areas. Even hall nurses listened as a group to report in one location while odd hall nurses listened as a group in another location (either medication or staff-break rooms). Tape recorded report was frequently interrupted (stopped and restarted), talked over (making the report difficult to hear), and overcrowded (with students or in held in a small location). Additionally, because the patient and the patient's environment were not visualized, unanswered questions about medications and patient care would often arise after change of shift.

Literature supports nursing handoff represents a prime-time for the possibility of miscommunication and adverse events (Sand-Jecklin & Sherman, 2013). The Agency for Healthcare Research and Quality (AHRQ, 2013) states a successful handoff requires effective communication between nurses to decrease medication errors and avoid sentinel events. The identified floor did not have an enforced structured communication tool for nursing handoff on non-critical care, adult floors. Situation-Background-Assessment-Recommendation (SBAR) is one type of format when giving verbal or tape recorded report, but the SBAR format was not enforced. Patient information received in handoffs was inconsistent and varied from nurse to nurse (A. Lagenbacher, personal communication, August 6,

2015). Further communication with organizational leadership supported the need for change. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores for the pilot floor were in the red zone (less than 50th percentile) in the categories of "communication with nurses" and "communication about medications" (A. Grimes, personal communication, August 12, 2015).

The current nursing handoff practice on the pilot floor was in transition. Staff were transitioning between tape recorded handoffs to verbal handoffs (A. Lagenbacher, personal communication, August 6, 2015). The pilot floor's nurse manager stated a verbal handoff should take place in the patient's room, but staff struggled with this change. Staff were reluctant to move away from tape recorded handoffs and often gave verbal handoffs at the nurse's station. Verbal handoffs in the patient's room consisted of: an introduction of the on-coming nurse by the off-going nurse and a brief statement to the patient to ring the call bell if the patient needed anything (A. Lagenbacher, personal communication, August 6, 2015). Handoff structure and practice on the pilot floor did not include the patient, patient goals, or collaboration with interprofessional team members.

Available Knowledge

A review of the literature shows BSR directly and indirectly impacts patient satisfaction, nursing satisfaction, and patient safety and quality of care. In addition, these three dominant themes often interlink to show that BSR can directly impact the clinical problem of ineffective communication. Through the

measurement of HCAHPS scores, the Centers for Medicaid and Medicare Services (CMS) verify that higher scores in the category of nursing communication signify increased patient satisfaction while verifying the lack of communication between patients and nurses through poor scores (Vines, Dupler, Van Son, & Guido, 2014). The traditional handoff process (taped or verbal) often leaves patients feeling left out of the decision making process regarding their own treatment plan and care (Radtke, 2013; Vines et al., 2014). However, research has shown BSR keeps the patient involved in care and improves nurse and patient satisfaction scores (Bradley & Mott, 2013; Cairns, Dudjak, Hoffmann, & Lorenz, 2013; Maxson, Derby, Wrobleski, & Foss, 2012).

Patient satisfaction. Patients agree that BSR creates a place and a specific time to bond and connect with their nurse, ask questions, and provide input concerning their own healthcare (Bradley & Mott, 2013; Jeffs, Beswick, et al., 2013; Vines et al., 2013). Other studies reveal patients felt BSR is a more effective and personalized approach than traditional taped or verbal report that occurs without input from the patient (Lu, Kerr, & McKinlay, 2014; Sand-Jecklin & Sherman, 2014). Last, BSR empowers the patient by allowing the patient to clarify information which decreases the risk for potential medication errors and allows for the correction and addition of information to the patient's medical chart (Lu et al., 2014).

Studies note changes to HCAHPS scores in the category of "nursing always communicated well" from 75% after the change of a taped handoff and handoff at the nurse's station to 87.6% post-implementation of BSR over a three-month period of time (Radtke, 2013). Studies that looked at the impact of BSR on patient satisfaction using scores other than HCAHPS, showed some degree of improvement in outcome measurements. Maxon et al. (2012) assessed the impact of BSR on patient satisfaction and patient perception of nursing care. All survey scores relating to patient satisfaction improved on the Likert scale (1 = best, 5 = worst) from an average score of 1.5 to 2 pre-implementation to 1 post implementation utilized for the study (Maxon et al., 2012). Sand-Jecklin and Sherman (2014) revealed a significant difference related to patients: knowing who their nurse was; being encouraged to be involved in their care; being included in shift report discussion; and feeling important information was being shared at handoff.

Nursing satisfaction. Evidence supports BSR impacts nursing accountability, teamwork, and prioritization of patient care impacting overall nurse satisfaction with this handoff practice. Nurses were more satisfied with patient involvement after BSR implementation and felt BSR allowed for clarification of misinformation and the potential reduction in errors through direct communication with each other and the patient (Bradley & Mott, 2013; Jeffs, Beswick, et al., 2013). Implementation of BSR gives nurses increased confidence

to care for their patient and improves teamwork and accountability (Cairns et al., 2013; Sand-Jecklin & Sherman, 2014). Because BSR takes place in the patient's room, the patient is visualized allowing for better prioritization of care and a promotion of patient safety (Jeffs, Acott, et al., 2013; Sand-Jecklin & Sherman, 2014). Survey results after BSR implementation show a change from 38% to 77% that nurses felt handoff report was concise and contained pertinent patient information (Cairns et al., 2013).

Patient safety and quality of care. Handoff at the bedside has a positive impact on adverse events (Halm, 2013). Literature supports BSR implementation positively affects patient fall rates and medication errors (Sand-Jecklin & Sherman, 2014). Additionally, BSR implementation showed a decrease in call light usage and improvements in areas of medication administration and nursing documentation (Cairns et al. 2013; Kerr, Lu, & McKinlay, 2013). Nurses and patients agree that BSR allowed for the clarification of misinformation and the potential for reduction in errors (Jeffs, Acott, et al., 2013; Lu et al., 2014).

Rationale

Two theoretical frameworks were utilized for the project: The Iowa Model and Lewin's Change Theory. The Iowa Model is an evidence-based practice (EBP) model utilized frequently in healthcare organizations and is requested on a regular basis for use in schools of nursing (Cullen & Adams, 2010). Use of this model inspires nurses and healthcare providers (HCPs) to examine their current

practice in the pursuit of increased patient safety and quality within an organization and supports the introduction, development, and evaluation of EBP change in nursing practice (Cullen & Adams, 2010). Because of the complexity of the implementation of the change process, a specific change theory was added for secondary support. Lewin's Change Theory of unfreezing, moving, and refreezing was a critical element to the implementation of BSR on an adult, medical/surgical floor (Radtke, 2013).

The Iowa model. Known for its practical, organizational application, the Iowa Model is a widely utilized EBP model in healthcare and is continuously referenced in nursing journals and clinical research (Doody & Doody, 2011). The model identifies a clinical problem as a *trigger*. A trigger can be either problem (patient-care) or knowledge (standards of practice) focused (Doody & Doody, 2011). Once the clinical problem has been *triggered*, the model follows seven steps. The first step is to choose a priority topic. The nurse must determine a clinical problem of organizational significance (Cullen & Adams, 2010). After organizational priority has been established, the final steps in the model are: the formation of a team to address the problem; a search and critique of the literature; implementation of a pilot change on one or two units in the organization; and evaluation of the change (Cullen & Adams, 2010).

Lewin's change theory. According to Adams and Cullen (2011), EBP models (like The Iowa Model) require additional support during the change

process; therefore, Lewin's Change Theory was integrated as a secondary theoretical framework. Lewin's three phase theory of change is a traditional model that views change as a balancing act. Forces (driving or restraining) work in opposite direction to either propel or hold back an organization towards a proposed change (White & Dudley-Brown, 2012). The first phase is *unfreezing*. In this phase, the current situation is "unfrozen" through motivation to change. The second phase is the *moving phase*. In this phase, the organization attempts to find a balance between the driving and restraining forces (White & Dudley-Brown, 2012). Last, *refreezing* happens after implementation of the change in order to maintain the change process within the organization (White & Dudley-Brown, 2012). Identification of barriers and an evaluation process is crucial to the refreezing phase (Radtke, 2013).

Specific Aims

The aim of this quality improvement project was to determine if implementing a practice change from the current handoff (verbal and taped) to a BSR handoff affected patient satisfaction with nursing communication, nursing satisfaction with a change in handoff practice, and medication errors. The project measured changes in satisfaction rates and medication errors on a medical-surgical unit in the adult population (older than 18 years of age) before and after the implementation of BSR over a four-week period of time.

The focus of this project identified if BSR is a standardized handoff method that improves nursing communication by analyzing patient satisfaction and medication errors. The project utilized an evidence-based strategy from AHRQ (2013) as a standardized method to determine if BSR is one type of handoff that shows continuity of care and positive patient outcomes, ensuring patient safety and allowing the patient to contribute to the plan of care, voice concerns, and ask questions (Maxson et al., 2012). For the purposes of this project, BSR was defined as a handoff process that takes place at the bedside with the off-going and on-coming shift nurses and patient and includes a structured communication tool and the computer on wheels (AHRQ, 2013).

Methods

Context

The QI project was implemented at a Pennsylvania acute care facility supporting surgical and regional trauma services. The pilot floor included two private and 21 semi-private adult rooms that accommodated 44 patients. Patients were primarily admitted with neurological, trauma, or orthopedic-surgical diagnoses. The target population was admitted adults older than 18 years of age. The clinical problem of ineffective communication was addressed.

Intervention

A BSR project team was formed comprising of the DNP student, the medical-surgical nursing director, and the pilot floor nurse and clinical managers.

Pilot floor nursing staff on were verbally informed of the upcoming change in handoff practice by the nurse and clinical managers during unit meetings. An initial project meeting was scheduled to discuss the current handoff process and review the BSR intervention strategy. Nurse leaders and staff members from pharmacy, physical therapy, dietary, and physicians from orthopedics, neurology, and trauma departments (that have pilot floor stakeholder involvement) were consulted for current views, challenges, and concerns prior to the initial meeting. Outcomes and goals for the project were reviewed. Ideas from the initial meeting were utilized to customize a standardized handoff tool also called the one-page checklist (Appendix A).

After completion of the of the standardized handoff tool, the BSR project team scheduled four education and training sessions over two weeks for all staff RNs on the pilot floor. Training took place on the pilot floor and followed a set of slides with talking points that were modified for the facility and designed to educate and train staff on how to a conduct BSR with patients and family members (AHRQ, 2013). The DNP student, clinical manager, and floor manager were assigned as point persons and were used for staff concerns and questions related to BSR implementation (AHRQ, 2013). BSR implementation started at the end of education and training and was measured for a period of four weeks.

The one-page checklist was utilized as a structured communication tool to standardize the process of BSR on the pilot floor (Appendix A). Six basic

elements were addressed. The nurse could carry the one-page checklist as a reminder to ensure all steps of the process were carried out (AHRQ, 2013). The off-going nurse introduced the on-coming nurse to the patient and family. The patient and any included family were invited to BSR (AHRQ, 2013). The computer on wheels (COW) was utilized to access the patient's medical chart in the patient's room and a verbal report was given with patient and family using SBAR in language patient and family could understand. Specific SBAR questions were included on the checklist (AHRQ, 2013). Step four included a focused patient and safety assessment, including a visual sweep of the room and a visual inspection of the patient's lines, wounds, drains, catheters, or intravenous (IV) sites (AHRQ, 2013). Step five was a review of tasks such as: medication administration, laboratory and test results, and any forms that needed completed. In step five, input from interdisciplinary members from the initial project meeting was considered. A check was added to ensure patients were asked by the nurse about medication side-effects during medication administration. Step six identified patient and family needs or concerns. The patient was asked to identify a goal for the day. The patient's goal was written on the whiteboard in the patient's room, and the goal was addressed at the next handoff (AHRQ, 2013). Expected time of BSR was two to five minutes per patient (AHRQ, 2013).

Patients were notified of BSR upon admission. Patients also received a verbal notification of BSR from the off-going shift nurse. Patients had the option

to refuse to participate and ask family members to stay for BSR. If the patient was asleep, off the floor, refused to participate, or if sensitive information needed to be shared between nursing staff and not with the patient at the bedside, report took place at the nurse's station (AHRQ, 2013). A visual safety check of the room was still made by the oncoming nurse if the patient was not included in BSR (AHRQ, 2013). Patient participation and nurse compliance was tracked through a BSR compliance sheet created for the study. Each RN was asked to monitor the number of patients participating or not participating in BSR during the study period.

Study of the Intervention

Medication errors and patient satisfaction. The project followed a pretest-posttest design. Medication error rates using facility event databases for the pilot floor and HCAHPS scores in the categories of "communication with nurses" and "communication about medications" were reviewed four weeks prior to the project intervention and used as baseline data. Post-implementation HCAHPS scores in the same categories and medication error rates, using facility event databases for the pilot floor, were collected within a month of the project ending date. Access for data collection was granted through the hospital chief nursing officer.

Nursing satisfaction. Pilot floor staff RNs were surveyed pre-implementation using the *Nursing Survey for Bedside Report Project* (Appendix

B). The survey was issued through Survey Monkey using an anonymous web link. Nurses were sent the web link through an email from the floor manager. The survey asked staff to answer six questions using a five-point Likert scale (1 = strongly agree to 5 = strongly disagree) to specify the degree they agreed or disagreed with handoff practice (Cairns et al., 2013). A seventh question was open-ended and asked the respondent to list their top two concerns if BSR was implemented on their unit (Cairns et al., 2013). The survey was modified with permission from the author. Post-implementation, staff were surveyed within a four-week time frame of the project end date using Survey Monkey. Post-implementation survey added two questions: 1) BSR and improved teamwork and accountability and 2) staff concerns following BSR implementation (Cairns et al., 2013).

Compliance. Nurses were asked to use the BSR compliance sheet at the beginning of their shift to monitor patient participation and nurse compliance with the QI project. The sheet monitored patient load, the number of patient's participating and not participating in BSR, as well as the reasons for non-participation. Sheets were collected weekly by the DNP student. No personal patient or nursing data was collected on the compliance sheets.

Measures

Two groups of data (pre- and post-implementation) were compared for changes in medication error rates, patient satisfaction, and nurse satisfaction using

a two sample *t*-test. In addition, data from the BSR compliance sheet was analyzed and displayed in tables as a simple percentage change from pre- to post-implementation to show nurse compliance and patient participation in BSR.

The pilot floor included 37 RNs. All staff, full and part-time, with the exception of the clinical and nurse managers were sampled (n = 35). Exclusion criteria included travel or float staff and ancillary staff. Recruitment for the pre-implementation nursing satisfaction survey was through word of mouth in unit staff meetings and hospital email with a link to the survey. All survey responses were anonymous and included an electronic informed consent.

The patient sample for the project was adult patients on a medical-surgical floor. Using convenience sampling, patients admitted to the pilot floor were sampled during the four-week study time frame. Inclusion criteria were adult patients, over age 18 years, admitted to the pilot floor.

Ethical considerations. Petition for facility and academic institutional board review (IRB) approval was requested and granted before project implementation. Upon admission, patients were provided a tri-fold brochure that explained BSR, the times of BSR, and the role of the patient and the family member in BSR (AHRQ, 2013). In addition, the off-going nurse verbally invited the patient to participate in BSR. This allowed the patient the opportunity to refuse participation in BSR and included family members in BSR, if desired (Maxon et al., 2012). No personal patient information was collected.

Results

Compliance for the study was calculated using the BSR compliance sheet and analyzed for nurse compliance with the QI study, patient participation with BSR, and patient non-participation with BSR. Initial nurse compliance with BSR was respectable in Week 1 at 47%; however, in the following weeks, the percentage of nurse compliance consistently declined. Week 4 showed compliance at less than 3% (Figure C1). The percentage of patient participation was consistent (between 60 and 82%) for all four weeks (Figure C2). Last, the majority (56%) of non-participating patients were reported asleep while only a small amount (7%) refused to participate in BSR (Figure C3).

Data collected from the *Nursing Survey for Bedside Report Project* survey showed mixed results. Nurses who agreed or strongly agreed that initial patient assessment was consistent with information received in report increased from pre- (n = 18, 66.67%) to post-implementation (n = 15, 86.67%). Nurses who agreed or strongly agreed that report was concise and contained pertinent patient information remained mainly unchanged from pre- (n = 18, 50%) to post-implementation (n = 15, 53%). After implementation of BSR, a higher percentage of nurses felt time negatively impacted change of shift report. Survey results showed an increased number of nurses agreed or strongly agreed (from 38.8%, n = 18 to 53.33%, n = 15) the time to receive shift report was excessive. Additionally, results showed an increased percentage of nurses felt the time

required to complete report interfered with their ability to complete change of shift report within their scheduled shift (from 27.78%, n = 18 to 50% n = 14). Survey results were not statistically significant (Table C1).

Results of HCAHPS surveys for the pilot floor in the category of "communication with nurses" showed positive results post-implementation. Three sub-categories for patient satisfaction related to communication with nurses were analyzed. Results for answers usually and always increased significantly (α = 0.05, p = 0.03) in the sub-category "nurses listen carefully to you." Interesting, this sub-category had the largest percentile change from pre-implementation (n = 27, 85.19%) to post-implementation (n = 19, 100%). After implementation of BSR, increased percentile changes were also noted in the other two nursing communication categories. Patients surveyed in the usually to always category stated nurses treated them with courtesy and respect and explained in a way they understood 100% of the time post-implementation (n = 19) (Figure C4).

Risk management reported one medication error in May and two medication errors in June for Tower 11 (H. Nedrok, personal communication, July 13, 2016). Results of HCAHPS surveys in the category of "communication about medications" showed mixed results. After completion of the QI project, significant change (α = 0.05, p = 0.01) was noted for patients answering usually or always in the sub-category "tell you what new medicine was for" from pre-implementation (n = 21, 76.19%) to post-implementation (n = 19, 100%).

However, the sub-category "staff describe medication side effect" resulted in a significant decrease ($\alpha = 0.05$, $p = 0.02$) from pre-implementation (n = 21, 100%) to post-implementation (n = 19, 70%). The overall category of "communication about medication" remained largely the same from pre- (n = 21, 84.38%) to post-implementation (n = 19, 86.67%) (Figure D5).

Summary

Project outcomes suggest that BSR improves patient satisfaction with nursing communication. Results show increases in all areas of HCAHPS categories of "communication with nurses" after study implementation (Figure C4). Overall, nurses were not satisfied with the practice change and felt that BSR impacted shift time and the ability to complete their work within their scheduled shift (Table C1). This perception barrier may have contributed to poor compliance rates. Time was not measured during the study and could be suggested for future studies. Literature states this is a common concern among nurses with the implementation of BSR (Radtke, 2013). However, evidence supports BSR does not increase handoff length and either decreases or does not change nursing overtime when measured (Cairns et al., 2013; Sand-Jecklin & Sherman, 2014; Wakefield, 2012). One category, initial assessment consistency, did show a positive change (Table C1) supporting literature that states BSR is a hand-off method that shows continuity of care, ensuring patient safety (Evans, Grunawalt, McClish, Wood, & Friese, 2012). Results did not support BSR decreased

medication errors (Figure C5). However, a significant change was noted in the way nurses communicated about new medications with patients (Figure C5). Overall, the study reinforced BSR as a structured handoff process that takes place at the bedside with the off-going and on-coming shift nurses utilizing the patient, a structured communication tool, and the COW (AHRQ, 2013).

Limitations

Several limitations were noted in the QI project. Because measurement of BSR implementation was four weeks, patient sample sizes from HCAHPS scores were limited. Patient sampling was anonymous. Due to the duration of the study and the anonymity of the patient sample, positive outcomes analyzed from HCAHPS scores post-implementation cannot be confirmed as a result of BSR. The QI study was conducted on one floor in one facility. Results cannot be generalized to a larger population without further study. Nurse compliance and sample size from the nursing satisfaction survey was also a limitation. Although education and training was completed, nurses were noted as resistant to a change in hand-off practice during the initial investigation for the project. Compliance steadily declined during the four-week study period providing concerns about the validity of the patient satisfaction scores.

References

Abraham, J., Kannampallil, T., & Patel, V.L. (2014). A systematic review of the

literature on the evaluation of handoff tools: implication for research and

practice. *Journal of the American Medical Informatics Association,*

*21,*154-162. doi:10.1136/amiajnl-2012-001351

Adams, J.M., & Osborne-McKenzie, T. (2012). Advancing the evidence base for

a standardized provider handover structure: Using staff nurse descriptions

of information needed to deliver competent care. *Journal of Continuing*

Education in Nursing, 43(6), 261-266.

doi:10.3928/00220124-20120215-88

Agency for Healthcare Research and Quality (AHRQ). (2013). *Nurse bedside*

shift report: Implementation handbook [PDF document]. Retrieved from

http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strat

egy3/Strat3_Implement_Hndbook_508.pdf

Bradley, S., & Mott, S. (2013). Adopting a patient-centered approach: An

investigation into the introduction of bedside handover to three rural

hospitals. *The Journal of Clinical Nursing, 23*, 1927-1936.

doi:10.1111/jocn.12403

Cairns, L.L., Dudjak, L.A., Hoffmann, R.L., & Lorenz, H.L. (2013). Utilizing

bedside shift report to improve the effectiveness of shift handoff. *The

Journal of Nursing Administration, 43*(3), 160-165.

doi:10.1097/NNA.0b013e318283dc02

Cullen, L., & Adams, S. (2010). An evidence-based practice model. *Journal of

PeriAnesthesia Nursing, 25*(5), 307-310. doi: 10.1016/j.jopan.2010.07.004

Doody, C. M., & Doody, O. (2011). Introducing evidence into nursing practice:

Using the IOWA model. *British Journal of Nursing, 20*(11), 661-664.

doi:10.12968/bjon.2011.20.11.661

Evans, D., Grunawalt, J., McClish, D., Wood, W., & Friese, C.R. (2012). Bedside

shift-to-shift nursing report implementation and outcomes. *MEDSURG

Nursing, 21*(5), 281-292. Retrieved from

http://www.medsurgnursing.net/cgi-bin/WebObjects/MSNJournal.woa

Griffin, T. (2010). Bringing change-of-shift report to the bedside: a patient-and

family-centered approach. *The Journal of Perinatal & Neonatal Nursing,

24*(4), 348-353. doi:10.1097/JPN.0b013e3181f8a6c8

Halm, M.A. (2013). Nursing handoffs: Ensuring safe passage for patients.

American Journal of Critical Care, 22(2), 158-162

http://dx.doi.org/10.4037/ajcc2013454

Jeffs, L., Beswick, S., Acott, A., Simpson, E., Cardoso, R., Campbell, H., &

Irwin, T. (2013). Patients' views on bedside nursing handover: Creating a

space to connect. *Journal of Nursing Care Quality, 29*(2), 149-154.

doi:10.1097/NCQ.0000000000000035

Jeffs, L., Simpson, E., Irwin, T., Beswick, S., & Cardoso, R. (2013). The value of

bedside shift reporting: Enhancing nurse surveillance, accountability, and

patient safety. *Journal of Nursing Care Quality, 28*(3), 226-232.

doi:10.1097/NCQ.0b013e3182852f46

The Joint Commission (TJC). (2014). *National patient safety goals effective

January 1, 2014: Hospital accreditation program.* Retrieved from

http://www.jointcommission.org/assets/1/6/HAP_NPSG_Chapter_2014.pdf

Kerr, D., Lu, S., & McKinlay, L. (2013). Bedside handover enhances completion

of nursing care. *Journal of Nursing Care Quality. 28*(3), 217-225.

doi:10.1097/NCQ.0b013e31828aa6e0

Long, L. (2012). Impressing patients while improving HCAHPS. *Nursing

Management, 43*(12), 32-37.

doi:10.1097/01.NUMA.0000422891.99334.68

Lu, S., Kerr, D., & McKinlay, L. (2014). Bedside nursing handover: Patients'

opinions. *International Journal of Nursing Practice, 20*, 451-459.

doi:10.1111/ijn.12158

Maxson, P.M., Derby, K.M., Wrobleski, D.M., & Foss, D.M. (2012). Bedside

nurse-to-nurse handoff promotes patient safety. *Medsurg Nursing, 21*(3),

140-145. Retrieved from http://www.medsurgnursing.net/cgi-

bin/WebObjects/MSNJournal.woa

Radtke, K. (2013). Improving patient satisfaction with nursing communication

using bedside shift report. *Clinical Nurse Specialist, 27*(1), 19-25.

doi:10.1097/NUR.0b013e3182777011

Sand-Jecklin, K., & Sherman, J. (2013). Incorporating bedside report into nursing

handoff: Evaluation of change in practice. *Journal of Nursing Care*

Quality, 28(2), 186-194.

doi:10.1097/NCQ.0b013e31827a4795

Sand-Jecklin, K., & Sherman, J. (2014). A quantitative assessment of patient and

nurse outcomes of bedside nursing report implementation. *Journal of*

Clinical Nursing. 23, 2854-2863, doi:10.1111/jocn.12575

U.S. Department of Health and Human Services. (2013). *2013 annual progress*

report to congress: National strategy for quality improvement in health

care. Retrieved from

http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm#execsumm

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.

Journal for Nurses in Professional Development, 30(4), 166-173.

doi:10.1097/NND.0000000000000057

Wakefield, D. S., Ragan, R., Brandt, J., & Tregnago, M. (2012). Making the

transition to nursing bedside shift reports. *The Joint Commission Journal*

on Quality and Patient Safety, 38(6), 243-353. Retrieved from

http://www.jcrinc.com/the-joint-commission-journal-on-quality-and-

patient-safety/

White, K. M., & Dudley-Brown, S. (2012). *Translation of evidence into nursing*

and health care practice. New York, NY: Springer Publishing.

APPENDIX A. AHRQ BEDSIDE REPORT CHECKLIST

From "Nurse Bedside Shift Report: Implementation Handbook [PDF Document]," by the Agency for Healthcare Research and Quality, 2013. Copyright 2013 by the Agency for Healthcare Research and Quality. Reprinted with permission.

Bedside Shift Report Checklist

☐ Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report.

☐ Open the medical record or access the electronic workstation in the patient's room.

☐ Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.

> **S** = **Situation**. What is going on with the patient? What are the current vital signs?
>
> **B** = **Background**. What is the pertinent patient history?
>
> **A** = **Assessment**. What is the patient's problem now?
>
> **R** = **Recommendation**. What does the patient need?

☐ Conduct a focused assessment of the patient and a safety assessment of the room.
- Visually inspect all wounds, incisions, drains, IV sites, IV tubings, catheters, etc.
- Visually sweep the room for any physical safety concerns.

☐ Review tasks that need to be done, such as:
- Labs or tests needed
- Medications administered
- Forms that need to be completed (e.g., admission, patient intake, vaccination, allergy review, etc.)
- Other tasks: _____

☐ Identify the patient's and family's needs or concerns.
- Ask the patient and family:
  - *"What could have gone better during the last 12 hours?"*
  - *"Tell us how your pain is."*
  - *"Tell us how much you walked today."*
  - *"Do you have any concerns about safety?"*
  - *"Do you have any worries you would like to share?"*
- Ask the patient and family what the goal is for the next shift. This is the patient's goal— not the nursing staff's goal for the patient.
  - *"What do you want to happen during the next 12 hours?"*
  - Follow up to see if the goal was met during the verbal SBAR at the next bedside shift report.

Adapted from the Emory University Bedside Shift Report Bundle.

AHRQ
Agency for Healthcare Research and Quality

Guide to Patient and Family Engagement

APPENDIX B. NURSING SURVEY FOR BEDSIDE REPORT PROJECT

From "Utilizing Bedside Shift Report to Improve the Effectiveness of Shift Handoff," by L.L. Cairns, L.A., Dudjak, R.L. Hoffmann, and H.L. Lorenz, 2013, *The Journal of Nursing Administration, 43*, 160-165. Copyright 2013 by Lippincott Williams & Wilkins. Reprinted with permission.

Nursing Survey for Bedside Report Project (All answers are anonymous)
Key: 1 = I strongly agree   3 = I neither agree nor disagree   5 = I strongly disagree

1. Currently, the time required to receive end of shift report is excessive.

<div align="center">1   2   3   4   5</div>

2. Report is concise and only contains information pertinent to the patients' care.

<div align="center">1   2   3   4   5</div>

3. My initial assessment of my patient(s) is consistent with the information I received in report (ie. infusion rates, dressing change, mental status).

<div align="center">1   2   3   4   5</div>

4. Nurses on my unit are open to me asking them questions after I listen to their report.

<div align="center">1   2   3   4   5</div>

5. Nurses on my unit are available if I want to ask them questions after I listen to report.

<div align="center">1   2   3   4   5</div>

6. Currently, the time required for me to report on my patients interferes with my ability to complete my work within my scheduled shift.

<div align="center">1   2   3   4   5</div>

7. If my unit was to implement bedside shift report, my top two concerns would be:
_____
_____

Additional questions added for post-project assessment:

8. Implementation of bedside shift report has improved team work and accountability on my unit.
<div align="center">1   2   3   4   5</div>

9. My top two concerns since the implementation of bedside shift report are:
_____
_____
_____

APPENDIX C. DATA RESULTS FROM THE QI STUDY

Figure C1

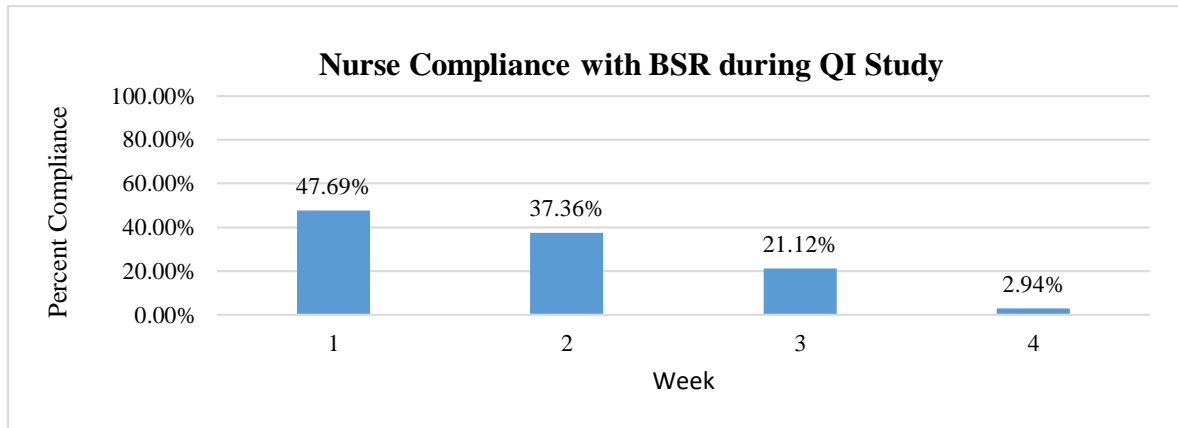*Results from Nurse Compliance with BSR*

Figure 1. This figure represents nurse (n=35) compliance with the QI study of BSR over the four-week period of time. Initial compliance is positive; however, a rapid decrease in BSR compliance is demonstrated.
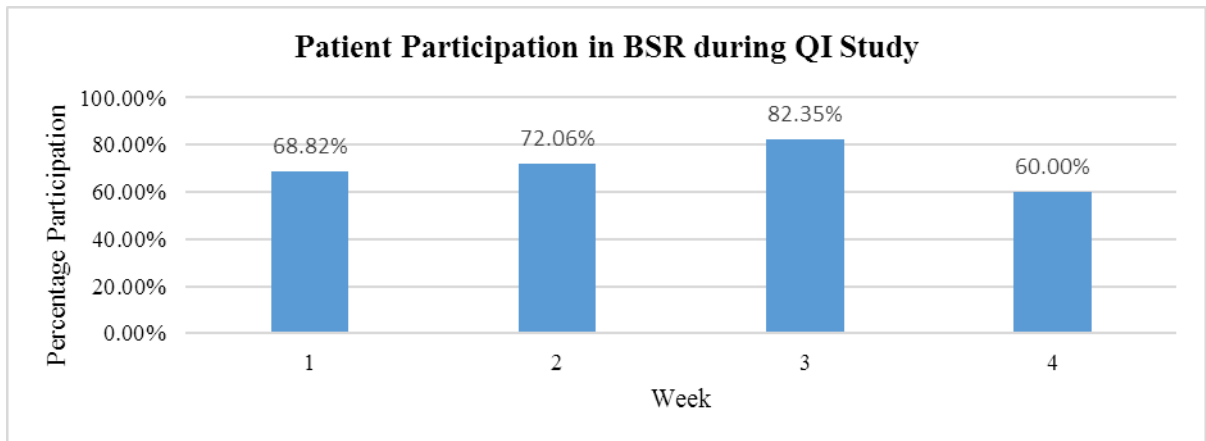
Figure C2

Results of QI Study Patient Participation

Figure 2. This figure represents patient participation with BSR from the BSR compliance sheets collected over the four-week study period. At least 60% of the patients consistently participated in BSR for the duration of the study period.

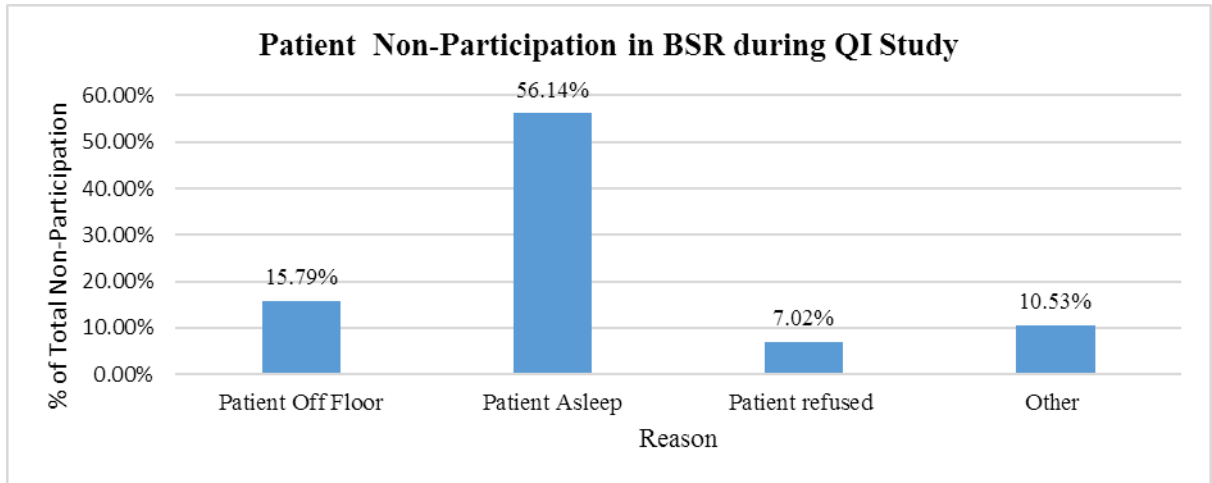# APPENDIX C. DATA RESULTS FROM THE QI STUDY

Figure C3

Results from Patient Non-Participation with BSR

Figure 3. This figure represents reasons why patients did not participate in BSR during the QI study as reported by pilot floor nurses from BSR compliance sheet data. The majority of patients were reported asleep. Only a small amount of patients (7%) refused BSR.

APPENDIX C. DATA RESULTS FROM THE QI STUDY

From "Utilizing Bedside Shift Report to Improve the Effectiveness of Shift Handoff," by L.L. Cairns, L.A., Dudjak, R.L. Hoffmann, and H.L. Lorenz, 2013, *The Journal of Nursing Administration, 43*, 160-165. Copyright 2013 by Lippincott Williams & Wilkins. Adapted with permission.

Table C1

Results in the Agree to Strongly Agree Category Pre- and Post-implementation from the Nursing Survey for Bedside Report Project Survey

Statement	PRE		POST		
	n	% Agree or Strongly Agree	n2	% Agree or Strongly Agree3	*p*-values
Currently, the time required to receive end of shift report is excessive.	18	38.89%	15	53.33%	0.20341
Report is concise and only contains information pertinent to the patient's care.	18	50.00%	15	53.33%	0.42441
My initial assessment of my patient(s) is consistent with the information I received in report (i.e. infusion rates, dressing change, mental status).	18	66.67%	15	86.67%	0.08508
Nurses on my unit are open to me asking them questions after I listen to their report.	16	93.75%	14	85.71%	0.23201
Nurses on my unit are available if I want to ask them questions after I listen to report.	18	77.78%	15	60.00%	0.13422
Currently, the time required for me to report on my patients interferes with my ability to complete my work within my scheduled shift.	18	27.78%	14	50.00%	0.09888

APPENDIX C. DATA RESULTS FROM THE QI STUDY

Figure C4

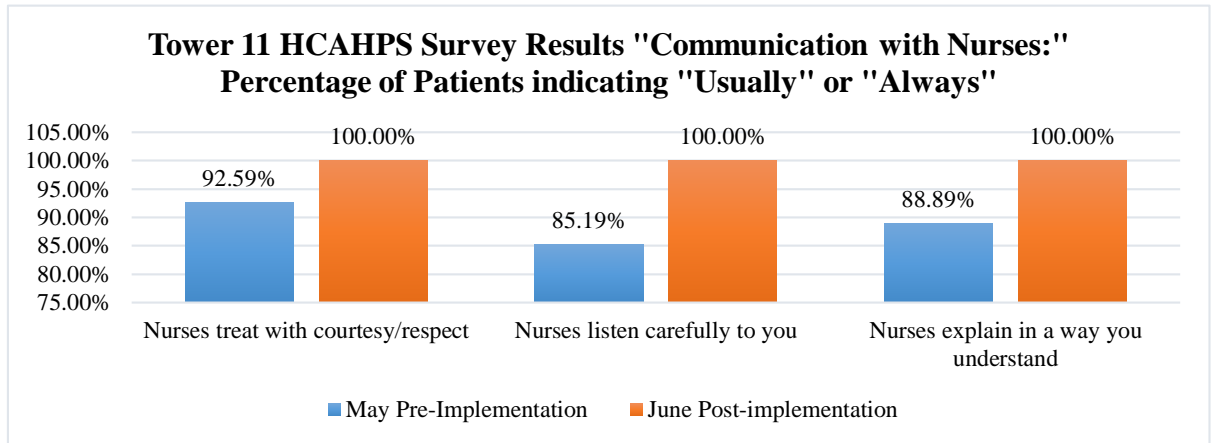*Results from HCAHPS scores: Communication with Nurses*

Figure 4: This figure shows pilot floor HCAHPS survey results in the category of "communication with nurses." All sub-categories showed positive change post-implementation. The sub-category "nurses listen carefully to you" was statistically significant (α=0.05, p=0.03).

Figure C5

Results of HCAHPS Scores: Communications About Medications
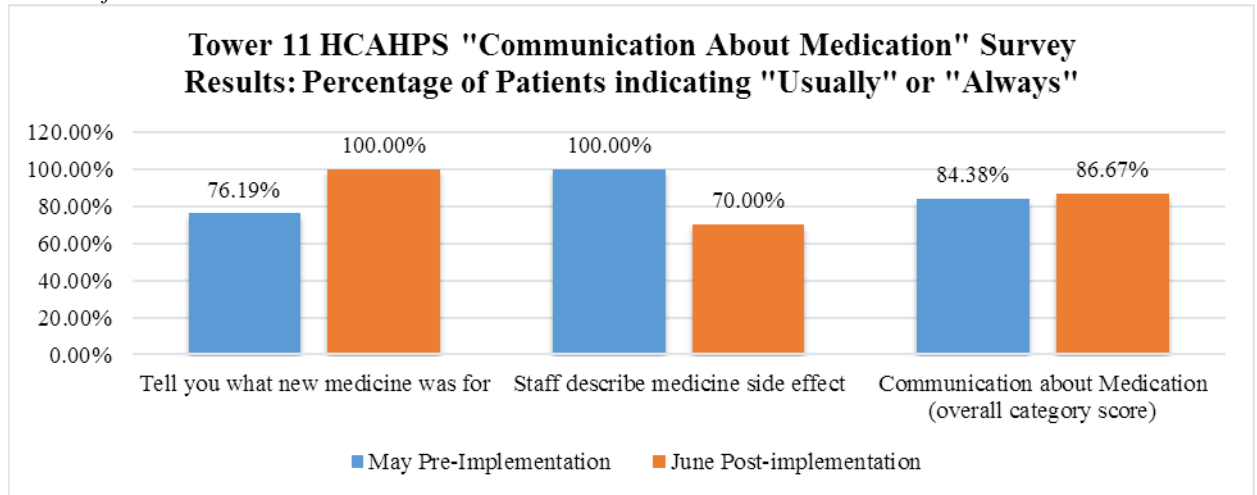

Figure 5: This figure shows HCAHPS survey results in the category of "communication about medications." The overall category score is included. Results in the sub-category "tell you what the new medicine was for" showed a positive percentile increase pre-and post-implementation and were statistically significant (α=0.05, p=0.01).

APPENDIX D.

Statement of Original Work and Signature

I have read, understood, and abided by Capella University's Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA *Publication Manual*.

Learner name and date	Karen Burk 8/19/2016
Mentor name and school	Marylee Bressie Capella University