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Educating Nurses on SBAR Tool Implementation for End-of-Shift Reporting

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Abstract

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MS.H.Ed, Capella University, 2019

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Project Submitted in Partial Fulfillment

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Doctor of Nursing Practice

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Abstract

Patient information transfer during nursing end-of-shift reporting remains a complicated process that lacks universal standardization. This lack of standardization was illustrated at the project site, a detention center in the northeastern United States. Deficiencies and gaps in the health care information of patients during end-of-shift reporting lacked consistence and congruency. This project was developed and implemented to educate the nursing staff at the project site on using the situation–background–assessment–recommendation (SBAR) tool during patient information transfer at cell-side in the facility infirmary. The practice-focused question that guided this project was whether a staff education on an SBAR communication tool designed to improve patient information transfer during cell-to-cell end-of-shift reporting would be perceived by staff as satisfactory and helpful in increasing their knowledge and likelihood of using the SBAR handout in practice. Knowle's adult learning theory and its five assumptions were the structural foundation for the program. Participants ($N = 14$) were asked to complete a post training evaluation. The evaluation consisted of five topics to rated using numerical values (1 = *strongly disagree* to 5 = *strongly agree*). Results were collected and analyzed using SPSS software. The findings revealed the program enhanced nursing knowledge and increased the likelihood of future use of the tool ($M = 4.76$). Correctional health teams are challenged with providing safe, quality, efficient health care to a vulnerable population . Cell-side end-of-shift SBAR reporting with patient inclusivity can promotes positive social, accountability, and continuity of care when transitioning into the community health care system. This has potential implications for positive social change.

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Dedication

To all those little girls who were told they were not smart enough to be a doctor.

Acknowledgments

To my extremely supportive family, friends, and mentors who have stood by my side, encouraged me when I needed it, and understood when I could not participate in events. I love you all. I must also acknowledge Dr. Robert McWhirt and countless faculty members for their continued guidance, patience, and understanding during this journey. Nothing can be achieved alone. It takes a village. And, lastly, to my dad, who wasn't by my side to see it, but I know he's with me just the same. Thank you for the conversation we had so many years ago at Jule's restaurant. That one conversation gave me the motivation and ambition—it just took a long time for me to know it.

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Section 1: Nature of the Project

Introduction

According to the Joint Commission National Patient Safety Goal (2010), approximately 80% of serious patient errors occur as a result of communication problems during end-of-shift reporting or patient handoff. The concern of ineffective communication has led the Joint Commission to identify communication as a National Patient Safety Goal—specifically, addressing errors in handoff communication (2008). According to the Joint Commission Center for Transforming Healthcare (2008), ineffective shift reporting is a major contributing factor to adverse events. Defining and ensuring a quality transfer of patient information prompted the Joint Commission (2010) to establish a National Patient Safety Standard specific to handoff communication. O'Rourke et al. (2018) stated,

> Ineffective nurse-to-nurse handoff is a global safety threat, yet there is a lack of empirical evidence that identifies core components to a typical nurse-to-nurse handoff. Barriers to successful transfer of patient information include frequent interruptions, too little or too much information, time constraints, poor communication skills, and inability to determine pertinent information (p 1660).

Problem Statement

Providing safe, effective, quality health care to incarcerated individuals presents challenges beyond traditional health care facilities. The National Commission on Correctional Health Standards (NCCHC, 2018) identifies that patient and healthcare provider complaints regarding the quality of care delivery of nursing care necessitates a

need for further investigation. According to Gage (2013), patient complaints are a key indicator of the quality of care delivery; complaints by incarcerated individuals are manifested as grievances in a correctional health care environment.

To identify factors associated with medical complaints at the project site, I conducted a medical record audit in conjunction with observations of end-of-shift reporting. Random audits of inmate–patient medical records involving the review of medical records identified missed physicians' orders, non-reported laboratory results, outpatient referral follow-up appointments not being scheduled, and physician telephone orders not being signed off by the appropriate provider. Observations during end-of-shift reporting were conducted by the facility director of nursing and by me. Observations on multiple shift changes and various calendar days yielded gaps in the transfer of pertinent patient information.

Purpose Statement

The purpose of this project was to educate nursing staff on the importance of using a standardized communication tool during cell-to-cell end-of-shift reporting. A technique used to facilitate prompt and appropriate communication refers to situation, background, assessment, and recommendation: SBAR. The practice-focused question for this project is: Will a staff education on an SBAR communication tool designed to improve patient information transfer during cell-to-cell end-of-shift reporting be perceived by staff as satisfactory and helpful in increasing their knowledge and likelihood of using the SBAR handout in practice?

Nature of the Doctoral Project

This project will follow the guidelines set forth in the Walden University *Manual for Development of a Staff Education Project*. I performed a review of the evidence using the online databases EMBASE, CINAHL, Medline, and Google Scholar. Key words for the search included *bed-side shift reporting, clinical handover, communication, nurse handoff, shift-to-shift report, shift turnover, end-of-shift reporting, clinical review guidelines, best practices from the Joint Commission, Institute of Medicine,* and *the National Commission of Correctional Health*. A review of the literature will emphasize the imperativeness of the use of a standardized SBAR tool to increase staff knowledge through education and ultimately enhance the quality of patient care.

Significance

The implementation of a standardized SBAR tool during end-of-shift cell-side rounds will not only improve patient outcomes but will significantly enhance the communication between shifts, providing clear and concise inmate patient information transfer while ensuring consistency and congruency of process. The use of a standardized handoff communication tool is in direct alignment with the Joint Commission's recommendation identified as one of the 2006 National Patient Safety Goals (Joint Commission Sentinel Event Alert 58, 2017). To maintain alignment with the initiatives outlined by the Institute of Medicine (IOM, 2000) publication on Crossing the Quality Chasm in access to healthcare and the Joint Commission Center for Transforming Healthcare (2008) to improve handoff communication to delineate patient harm. The

ability to provide quality healthcare to incarcerated individuals without discrimination or disparagement should be the goal of all healthcare institutions and healthcare providers.

Summary

Real or perceived challenges of ineffective or failed communication and transfer of patient information ultimately affect the congruency and quality of safe, efficient patient care (Tobiano et al., 2017). In Section 1, a gap in practice was identified which led to the development of the project question. In Section 2, I describe Knowles' theory of adult learning and the theory's application to this project, the evidence supporting the need for the project, and my role in planning, implementing, and evaluating project.

Section 2: Background and Context

Introduction

Defining and ensuring quality transfer of patient information led the Joint Commission (2010) to establish a National Patient Safety Standard specific to handoff communication. Research indicates that the implementation of bedside end-of-shift reporting could potentially improve the transfer of critical patient information. Tobiano et al. (2017) conducted a study to understand perceptions of the barriers encountered by nursing and shift reporting and the correlation to quality safe congruent patient care. Bedside handoff improves the transfer of information, improving efficiency, accountability, and overall safety of the patient (Tobiano et al., 2017). To address issues with this process involves first identifying the real or perceived barriers to the success of bedside handover. McAllen et al. (2018) sought to determine if bedside reporting improved patient safety and heightened nurse and patient satisfaction. Tobiano et al. and McAllen et al. outlined the concept of bedside shift reporting and the potential significance found through quantitative study outcomes. McAllen et al. (2017) indicated that the implementation of bedside shift reporting decreased patient falls by 27% and marginally increased nursing satisfaction.

Concepts, Models, and Theories

Malcom Knowles's (2005) assumptions included in the theory of adult learning will frame this project. Knowles's theory is based on five assumptions: (a) self-concept, (b) adult learner experience, (c) readiness to learn, (d) orientation to learning, and

(e) motivation to learn (McEwen & Wills, 2014). Table 1 depicts how this education project aligns with Knowles's five assumptions.

Table 1

Alignment of Adult Learning Theory With Project

Assumptions	Relationship to education program
Self-concept: The adult is self-directed towards learning.	To enhance base-line knowledge of patient information transfer at the cell-side
Experience: Experience is a resource for learning.	A majority of the nursing staff have no acute care experience. Seasoned nurses can provide additional support
Readiness to learn: Adults identify tasks based on their role.	Correctional nursing has few differences in task related to credential
Orientation to learning: Adults identify the need for solving problems	Miscommunication enhances staff frustrations and compromises patient care
Motivation to learn: Adults are internally motivated to learn.	Correctional nursing is a unique specialty, caring for a vulnerable population requires continued knowledge enhancements

Note. Adapted from *Theoretical Basis for Nursing* (4th ed.), by M. McEwen and E. Wills, 2014, Wolters Kluwer Health.

Relevance to Nursing Practice

Patient and health care provider complaints at the study site prompted random audits of inmate–patient medical records and observation of shift turnover reports. Preliminary conclusions indicated pertinent patient information was being omitted during end-of-shift reporting. Further review of the medical records identified missed physician orders, non-reported laboratory results, outpatient referral follow-up appointments not being scheduled, and physician telephone orders not being signed off by the appropriate provider. The identified deficiencies directly impact the safety and quality of patient care, length of patients' infirmary stay, and patients' return to optimal health. The identified

patient care deficiencies indicate the need for staff education to decrease the inconsistent and miscommunication of imperative patient information during nurse handoff.

The transfer of patient information has a multitude of labels: *nurse handoff, shift-to-shift reporting, bedside shift reporting*, and *nurse handover*. The research confirms these terms associated with the transfer of patient information have been used for decades; however, the concept of communication between nursing staff has recently been reexamined. According to Tobiano et al., (2017) conceptualizing bedside handoff improves the transfer of information, improving efficiency, accountability, and overall patient safety. Observations of chart audits of nurse-to-nurse end-of-shift reporting reveal that nurses are typically in a rush during end-of-shift reporting. Observation of end-of-shift reporting appears to be a task-focused event of the nursing staff as opposed to quality patient information transfer. Focusing on the task instead of the patient can lead to failure to transfer crucial patient information.

Poor and ineffective communication was a major contributing factor of sentinel events between 2009 and 2011 (Toccafondi et al., 2012). As a result of the staggering number of sentinel events, the Joint Commission (2010) established provision of care standard PC.02.02.01, element of performance (EP) 2, which requires that an organization's process for handoff communication provides the opportunity for discussion between the giver and receiver of patient information. A review of the literature identified commonalities among the causative factors associated with ineffective end-of-shift reporting include interruptions, novice nurses, and ineffectively developed communication skills of nursing staff, all of which can lead to negative patient

outcomes. Governing and regulatory bodies have yet to clearly define specific criteria or identify patient tools that can be used to standardized patient information transfer. Nonetheless, the Joint Commission (2017) initiated provision of care PC.02.02.01 and EP 2, although the provision lacks congruency in all health care arenas.

According to the Joint Commission (2017), ineffective and failed communications regarding patient care is a direct correlation to the lack of standardized procedures of patient information transfer and its success. Ineffective handoff and misinformation has become a noticeable problem within this particular health care arena. Medical record audits and observation of end-of-shift reports at the study site indicate pertinent patient information has been omitted in these processes. In reviewing the medical records, issues identified included missed orders, non-reported laboratory results, outpatient referral follow-up appointments not being scheduled, and telephone orders not being signed off by providers. To address this issue, the implementation of cell-side shift reporting using the SBAR technique of patient information transfer may increase continuity, congruency, and quality of care.

Federal Requirements

Patient safety is a critical component to health care delivery (IOM, 2001). Health care quality consists of six domains for health care systems: (a) safety, (b) effectiveness, (c) patient-centered, (d) timely, (e) efficient, and (f) equitable care (IOM, 2001). While the concept of end-of-shift reporting sounds simple, ineffective and poor patient handoff can negatively affect patient care. Ineffective communication can lead to avoidable sentinel events. As a result, the Joint Commission (2017) established national patient

safety goals specifically addressing patient handoff communication. The developed standard requires that organizations implement a specific process for handoff communication to minimize poor patient outcomes. The Joint Commission's (2017) PC.02.02.01 EP requires that organizations develop a process for handoff communication that promotes and provides for the opportunity for discussion between the giver and the receiver of patient information.

Guidelines and Best Practices

According to the Joint Commission (2017), ineffective and failed communications regarding patient care are due to a lack of standardized procedures for successful handoff. Ineffective handoff and misinformation have become a noticeable problem within this particular health care arena. Frequent medical record reviews and observations of shift turnover reports at the study site identified the omission of pertinent patient information transfer. A medical records audit identified missed orders, non-reported laboratory results, missed outpatient referral follow-up appointments, and telephone orders not being signed off by the provider. Staff education on the SBAR technique of patient information transfer in conjunction with cell-side end-of-shift reporting has the potential to increase continuity, congruency, and quality of patient care.

Local Background and Context

The site for this project is a detention center in the northeastern United States; the center has an average daily population of 450 individuals, 13% of which are female. The facility consists of general population dormitories, a medical step-down dormitory, a mental health dormitory and a 14-cell infirmary. The medical department is staffed with

nursing professionals 24 hours a day, 7 days per week. Department functions include: (a) daily physician rounds, (b) twice weekly psychiatry rounds, (c) daily mental health clinicians, (d) twice weekly dental services, (e) twice weekly radiology studies, and (f) daily laboratory specimen collections.

Current facility end-of-shift reporting involves a brief overview of the patient's status read from an email copy of a shift report that includes the following information: name, admitting date, admitting diagnosis, allergies, and current shift information. The director of nursing and I identified a gap in the transfer of patient information during end-of-shift reporting. Current department practice has a lack of consistency and congruency. Some staff members will practice cell-to-cell end-of-shift reporting, yet others simply read from the paper report sheet. Although the currently used document provides the basic information, it does not provide a clear and concise nursing evaluation, interventions, plan of care, and outcomes. In the assessment of current practices, I found that often the staff will copy and paste the information without updating relevant inmate patient information, such as the following:

- Cell number: The location within the infirmary where the patient is located
- Intake date: The admission to the facility information
- Infirmary admission diagnosis: Physician to document the medical diagnosis for admission into the infirmary
- Shift report: The process of patient information transfer from shift-to shift

Current practices of medical record audits and shift-to-shift patient information transfer are unstructured and poorly conducted, including end-of-shift reporting. The

ineffective information transfer impacts timely and appropriate care delivery, increases length of stay within the infirmary, introduces gaps in patient care delivery, leads to failures in patient safety, and increases incidence of medication errors (Director of Nursing, personal communication January 15, 2020). The transfer of patient care information is a complex component of nursing practice commonly fraught with challenges. Ineffective handoff or poor communication continue to be the leading cause of sentinel events (Elgin et al., 2019.

Consistency and the ability to effectively communicate pertinent clinical patient information decreases the risk of patient harm (American Nurses Association, 2012).

Role of the DNP Student

The purpose of this project is to educate nursing staff on the importance of using a standardized communication tool during cell-to cell end of shift reporting. The project question is: Will a staff education on an SBAR communication tool designed to improve patient information transfer during cell-to-cell end-of shift reporting be perceived by staff as satisfactory and helpful in increasing their knowledge and likelihood of using the SBAR handout in practice? My role for this project is to plan, implement, and evaluate an education program presented to nursing staff on the use of SBAR communication tool designed to improve patient information transfer during cell-to-cell end-of shift reporting, the perception of the benefits of SBAR, the likelihood of future use, and whether the program enhanced individuals knowledge. I will meet the following American Association of Colleges of Nursing (AACN) Essentials for the DNP upon completion of this project.

Essential I

The DNP graduate has the ability to address current and future practice issues using a strong scientific foundation for practice utilizing science-based theories and identify actions and advanced strategies to enhance, alleviate, and ameliorate health and health care delivery (AACN, 2020).

Essential II

Organizational and Systems Leadership for Quality Improvement and Systems thinking has been one of the most influential competencies during this course. The ability to align organizational cultures with patient needs to provide the best possible health care delivery; particularly with a vulnerable population is consistent with doctoral level knowledge and skills consistent with Essential II to eliminate health disparities, promote patient safety and excel in practice (AACN, 2020).

Essential VII

Clinical Prevention and Population Health for Improving the Nation's Health. Individuals who become incarcerated are often at a disadvantage when seeking accesses to health care within the community, therefore rendering them a vulnerable population when being detained (Sullivan Commission, 2004). In 1976 the U.S. Supreme Court set the guidelines for health care access for incarcerated as the results of the landmark case Estelle v. Gamble (1976.) as stated by the Legal Information Institute (n.d.) the incarcerated shall have reasonable access to health care service while detained. Incarcerated will be seen by a qualified health care professional in a timely manner (NCCHC, 2018). The primary goal when caring for such a vulnerable population is the

delivery of safe, efficient quality of care. In an often-forgotten specialty, correctional health is in direct alignment with population health. Individuals who are detained within a county detention center typically are short-term stays when compared to prisons which is traditionally a long-term environment following sentencing of the crimes. As indicated in Essential VII the DNP graduate engages in leadership to integrate and institutionalize evidence-based clinical prevention and population health services for individuals, aggregates, and populations (AACN, 2020).

Summary

Section 2 introduced Malcolm Knowles' theory of Adult Learning. My role and the role of an expert panelist were described. Connections of my role to the AACN DNP Essentials were outlined. The background and context for the project were detailed. The evidence supporting the importance of end of shift reporting tools was discussed. Section 3 will introduce the specific planning, implementation, evaluation and protections for the project.

Section 3: Collection and Analysis of Evidence

Introduction

In Section 3, I identify the driving forces that have led to the practice-focused question in this project, along with a description of evidence that was instrumental in the development and dissemination of an educational tool for nursing staff on the use of SBAR at cell-side for patients at the project site.

Practice-Focused Question

Nurse-to-nurse end-of-shift reporting has been a long-standing issue in patient care delivery. According to O'Rourke et al. (2018), challenges identified with quality patient information transfer are frequent interruptions, time constraints, poor communication skills, and inability to determine critical patient information. Ineffective nurse-to-nurse handoff jeopardizes patient safety, yet there remains a deficiency in empirical evidence that specifies the core components of the process (O'Rourke et al., 2018). This DNP project was guided by the following question: Will a staff education on the SBAR communication tool designed to improve patient information transfer during cell-to-cell end-of-shift reporting be perceived by staff as satisfactory and helpful in increasing their knowledge and the likelihood of using the SBAR tool in practice?

Sources of Evidence

I conducted a review of the evidence using the online databases EMBASE, CINAHL, Medline, and Google Scholar. Search terms included *bed-side shift reporting, clinical handover, communication, nurse handoff, shift-to-shift report, shift turnover,* and

end-of-shift reporting. The practice issue of shift-to-shift reporting has been a long studied concept, yet it remains a concern with respect to quality, safe, efficient care.

In direct observations of end-of-shift reporting, it became apparent that nurses are anxious to end their shift. The focus on the end-of-shift reporting can lead to inaccurate or missed critical patient information transfer. Examples of noted deficiencies included improper or missed essential medication identification and diagnostic study results not being communicated for health care provider review. Although these deficiencies may not result in a critical event, they do impact quality of care. Tobiano et al. (2017) conducted a study to understand perceptions of barriers encountered by nurses' end-of-shift report and the correlation to quality safe congruent patient care. Bedside handoff improves the transfer of information, improving efficiency, accountability, and overall safety of the patient (Tobiano et al., 2017). Alternatively, McAllen et al. (2018) sought to determine if bedside reporting improved patient safety and heightened nurse and patient satisfaction based on quantitative studies and outcomes. McAllen (et al., 2017) noted the implementation of bedside shift reporting decreased patient falls by 27%; although the researchers also found a marginal increase in nurses' satisfaction, they acknowledged a deficit in knowledge and understanding of bedside shift reporting.

Providing education to the nursing staff on the SBAR technique during end-of-shift patient information transfer, to be completed at cell-side, will decrease deficiencies in health care provider orders and involve patient in care delivery. Using a clinical reminder to promote the implementation and use of the SBAR reporting method may be necessary, especially for per-diem nursing staff. Many electronic medical record

programs can be developed to set up a clinical reminder for staff to complete the cell-side end-of-shift report to be completed prior to end of shift. These reminders or alerts can trigger the infirmary nurse that the documentation of the designated task is required (Dudley-Brown et al., 2016).

As identified by the Agency for Healthcare Research and Quality (AHRQ, n.d.), the clinical environment and social and relational organizational structure may contribute to adverse clinical events. Correctional health care is significantly impacted by organizational structure. However, the consistent use of the SBAR reporting method by practitioners can enhance the quality of patient information transfer (Dudley-Brown et al., 2016). Correctional facilities are governed by each state's correctional commission. Correctional facilities in New Jersey, for example, are governed by the New Jersey Department of Corrections. Although all correctional facilities are regulated at the state level, many facilities seek accreditation of the National Commission on Correctional Health (NCCHC). The NCCHC (2018) is an independent accrediting agency that has specific guidelines for health care delivery for incarcerated individuals. Detention centers wishing to deliver the best quality of care often seek this accreditation. Facilities have autonomy in policy specifics, such as the end-of-shift reporting method.

Utilizing communication and teambuilding strategies to get stakeholder buy-in to a new process can be challenging. Communication in health care delivery has been a challenge; however, the development of interpersonal relationships characterized by collaboration and partnerships can lead to improved patient outcomes (Dudley-Brown et al., 2016). Establishing a meeting with medical staff and county administration is

imperative for the implementation of a new process to involve stakeholders for process buy-in (Roussel, 2013). Providing data and literature supporting the significance of effective communication will increase understanding regarding the need for the change. Outlining the fiscal components associated with ineffective patient information transfer includes identifying how deficiencies or gaps in accurate patient information transfer can increase costs and decrease efficiency of care. Labor costs associated with repeat diagnostic studies impact the department budget and ultimately does not adhere to NCCHC J-E-09 (NCCHC, 2018)

In this project, I considered providing staff education using multiple teaching modalities: didactic, PowerPoint presentation, and a story board. Andragogy is the primary model of adult learning (Merriam et al., 2007); providing various teaching methods encourages learners to grasp the content based on their individual learning style. The greatest anticipated barrier for this project was buy-in from nursing staff and tolerance of correctional police during cell-side end-of-shift reporting. The new process will be monitored for efficacy and reliability in the improvement of patient information transfer and quality of care delivery.

Evidence Generated for the Doctorate Project

Participants included in the education program were 18 nurses: seven registered professional nurses, and 11 licensed practical nurses. Because of the COVID-19 pandemic, the facility has prohibited congregated meetings within the facility. As a result, the most efficient way to provide the educational project to the nursing staff was using an online platform. I used an online platform that provides video, audio, and

screensharing, and a date and time was chosen for staff to participate while on duty. Those not on duty at that time could participate in the presentation via webinar. Because of the nature of the environment and the limited number of nursing staff, several meetings were scheduled to ensure total staff participation. Emphasizing the SBAR technique as outlined by the Institute of Healthcare Improvement (IHI, 2017) two teaching methods were developed.

The initial teaching method was a PowerPoint presentation shared with the nursing staff during the online platform meetings. The presentation included the following:

- Objectives:
  - Nature and causes of communication breakdown in the patient information transfer during end-of-shift reporting
  - Define SBAR communication
  - Identify the benefits of using the SBAR method to improve patient information transfer during end-of-shift report and enhance quality of patient care at cell-side
- Current facility identified gaps
- Clinical communication
- Cell-side end-of-shift reporting
- Defining the SBAR method
- SBAR communication
- SBAR reporting

- SBAR example
- Tips for success
- SBAR resources
- Lesson review
- Questions/Concerns

In addition to the PowerPoint presentation, I created a story board to mirror the information provided to the nursing staff posted in the clinical environment to generate the clinical reminder. As reiterated by Dudley-Brown et al. (2016) the use of clinical reminders will motivate the nursing staff to continue the use of the process. This project aligned with the Walden University Manual for Staff Education. Approval from the Walden University Institutional Review Board (#04-25-22-0365610) was obtained prior to expert panel review and project implementation.

Analysis and Synthesis

Participants will complete the Staff Education Evaluation Form (Appendix B) upon completion of the project. Evaluation results will be tabulated using descriptive statistics. Effectiveness of the SBAR educational program will be determined based on the evaluation results of the likelihood to utilize the SBAR method and heighten knowledge.

Summary

Section 3 introduced the specific planning, implementation, evaluation and protections for the project. The gap in staff knowledge was identified in the process of cell-side end of shift reporting. The deficit is staff knowledge will be heightened upon

completion of the DNP project of cell-side end of shift reporting utilizing a standardized SBAR format. The educational program will increase continuity, congruency, and quality of care and is in direct alignment with the Essentials I, II, and VII as defined by the American Association of Colleges of Nursing Essentials of Doctoral Education for Advanced Nursing Practice (2006).

Section 4: Findings and Recommendations

Introduction

The purpose of this project was to educate nursing staff on the importance of using a standardized communication tool during cell-to-cell end-of-shift reporting. Patient complaints, missed physicians orders, and gaps in patient information during transfer indicated a need for improvement of end-of-shift reporting process at the project site, a detention center in the northeastern United States. The practice-focused question was: Will providing the nursing staff with an educational program on the use of an SBAR communication tool designed to improve patient information transfer during cell-to-cell end-of-shift reporting be perceived by staff as satisfactory and helpful in increasing their knowledge and likelihood of using the SBAR handout in practice? The following objectives were the driving force for heightening the knowledge base of the nursing staff at the study site: (a) identify nature and causes of communication breakdown in the patient information transfer during end-of-shift reporting, (b) define SBAR, and (c) identify the benefits of using the SBAR method to improve patient information transfer during end-of-shift report and enhance the quality of patient care at the cell-side.

Upon completion of the staff education presentation an evaluation form was provided to the participating nursing staff. Participants consisted of three registered professional nurses and 11 licensed practical nurses. The evaluation form (Appendix B) consisted of 10 questions using a Likert scale. Completed evaluation forms were collected after the education presentation and data were collected from those forms. The data were analyzed using SPSS software.

Findings and Implications

A total of 14 female nurses participated in the staff education project, and 100% (n = 14) of the participants completed the anonymous evaluation form. Seventy-one percent (n = 11) of the nurses were licensed practical nurses, 29% (n = 3) were baccalaureate prepared registered professional nurses, of which two where matriculating for their master degree in nursing. All participants worked rotating shifts with rotating assignments within the facility. The staff education evaluation form (Appendix B) focused on five content topics; each topic presented with specific content topic statements. Staff were asked to rate each statement from 1 = *strongly disagree* to 5 = *strongly agree* related to the content topic.

Table 2 presents the responses from participants to the evaluation form. The results of the summary evaluation by participants of the training ranged from a participation mean score of 4.7–5.0. The evaluation results identified the necessity of training and benefits of improved quality of care through the use of the SBAR tool at cell-side during end-of-shift reporting. The evaluation was focused on five areas with additional statements requiring participants to rate on the scale of 1 to 5.

Table 2

Summary Evaluation

Items	M	SD
Content		
The content was interesting to me	4.35	0.74
The content extended my knowledge of the topic	4.35	0.74
The content was consistent with the objectives	4.64	0.49
The content was related to my job	4.5	0.65
Objectives were consistent with the purpose/goals of the activity	4.71	0.46
Setting		
The platform was conducive to learning	4.78	0.42
The learning environment stimulated idea exchange	4.47	0.51
Facility was appropriate for the activity	4.92	0.26
Faculty/presenter effectiveness		
The presentation was clear and to the point	5	0
The presenter demonstrated mastery of the topic	5	0
The method used to present the material held my attention	4.85	0.36
The presenter was responsive to participants concerns	4.92	0.26
Instructional methods		
The instructional material was well organized	5	0
The instructional methods illustrated the concepts well	5	0
The handout materials given are likely to be used as a future reference	4.71	0.72
The teaching strategies were appropriate for the activity	5	0
Program objectives		
Identify nature and causes of communication breakdown in the patient information transfer during end-of-shift reporting	4.85	0.36
Define SBAR communication at the cell-side	4.71	0.46
Identify the benefits of using the SBAR method to improve patient information transfer during end-of-shift report and enhance the quality of patient care at the cell-side	4.85	0.36
M rating score	4.76	

Note. Statements were rated on a Likert scale in from 1 = *strongly disagree* to 5 = *strongly agree.*

Content

The participants were asked to rate five statements associated with the content of the education program. Fifty percent of the clinical nursing staff who participated in infirmary care agreed the topic was interesting; 35.7% of the nonclinical staff agreed that the topic was of interest to them. The mean was 4.35 and standard deviation 0.74.

Participants stated the project expanded their knowledge. Seven (50%) of the 14 staff members strongly agreed, two participants (35.7%) agreed, and two participants neither agreed nor disagreed (14.3%)m with a mean of 4.35 and standard deviation of 0.74. Among participants, 64.3% strongly agreed and 35.7% agreed that the content met the objectives, with a mean of 4.64 and standard deviation of 0.49.

Participants were asked if the education project related to their jobs and responsibilities while delivering patient care in the infirmary. In response, 57.1% strongly agreed that it was relevant to their care delivery, 35.7% agreed, and 7.1% neither agreed nor disagreed. The mean was 4.50 and standard deviation was 0.65. Participants were asked whether the project objectives were consistent with the purpose and goals of the activity, and 71.4% of the participants strongly agreed and 28.6% of the participants agreed, with a mean of 4.71 and standard deviation of 0.46.

Setting

Participants were asked to evaluate and rate three statements associated with the setting for the instructional program using the same scale of 1 to 5. Participants were asked to rate the platform and delivery method; 78.6% of the participants strongly agreed the platform was conducive to learning and 21.4% participants agreed, with a mean of 4.78 and standard deviation of 0.42. Among participants, 57.1% strongly agreed that the environment stimulated idea exchange and 42.9% of the participants agreed, with a mean of 4.47 and standard deviation of 0.5. Participants were asked if the facility was appropriate for the activity, and 92.9% strongly agreed the facility was appropriate, with a mean of 4.92 and standard deviation of 0.26.

Faculty/Presenter

Program participants were asked to evaluate and rate three statements associate with presenter of the program. When asked whether the faculty presenter's presentation was clear and to the point, 100% of the participants strongly agreed it was clear and concise. When asked whether the presenter demonstrated mastery of the topic, 100% of the participants strongly agreed the presenter had expert knowledge of the topic of the SBAR method to be conducted at cell-side during end of shift.

When asked whether the method used to present the material held their attention, 100% of the nursing staff using a PowerPoint presentation in conjunction with live one-on-one education agreed. The breakdown was 85.7% (n = 12) of the participants strongly agreed and 14.3% (n = 2) of the participants agreed, with a mean of 4.85 and standard deviation of 0.36. When asked whether the presenter was responsive to participants concerns, 92.9% (n = 13) of the participants strongly agreed and one participant (7.1%) agreed, with a mean of 4.92 and standard deviation of 0.26.

Instructional Methods

Program participants were asked to evaluate and rate three statements associated with the presenter of the program. Participants were asked if the presenter was well organized, and 100% (n = 14) strongly agreed the material was organized to promote and enhance learning. Participants were sked whether the instructional methods illustrated the outlined project concepts, and 100% (n = 14) of the participants strongly agreed.

All participants were provided additional individual copies of the presentation to use as a reference for future use. Participants were asked if they would be likely to use

the project handout materials, and 12 of the participants (85.7%) strongly agreed and 2 participants (14.3%) neither agreed nor disagreed, with a mean of 4.71 and standard deviation of 0.72. Participants were asked if the teaching strategies were appropriate for the activity, and 100% of the participants (n = 14) strongly agreed.

Program Objectives

Participants were asked to rate three statements associated with the program objectives. Participants were asked if the program met the objective of being able to identify the nature and causes of communication breakdown in patient information transfer during end-of-shift reporting. Of the participants, 12 (85.7%) strongly agreed and two (14.3%) agreed, with a mean of 4.85 and standard deviation of 0.36.

Participants were asked if they were able to define the SBAR communication method after the staff education program. In response, 71.4 % (n = 10) of participants strongly agreed and 28.6% (n = 4) agreed, with a mean of 4.71and standard deviation of 0.46. Participants were sked if they were able to identify the benefits of using the SBAR method to improve patient information transfer during end-of-shift reporting and enhance the quality in patient care at cell-side as a result of the education. Twelve respondents (85.7%) strongly agreed with the program objective statement, and 14.3% (n = 2) participants agreed, with a mean of 4.85 and standard deviation of 0.36.

Recommendations

Two major components should be utilized when determining the efficacy and success of the SBAR method during end-of shift at the cell-side reporting. Providing education to the nursing staff on the SBAR (situation, background, assessment, and

recommendation) technique during end-of-shift patient information transfer to be completed at the cell-side will decrease deficiencies in health care provider's orders while involving the patient in care delivery. Frequent observation and monitoring of staff participation in the patient information transfer at the cell-side.

Random comprehensive medical chart review using the facilitates continuous quality improvement (CQI) continuity of care, intake screening, and infirmary care. Random medical record audits will encompass 25% of the currently incarcerated patients. Initial evaluation will be completed one month after the implementation of cell-side end-of-shift reporting utilizing the SBAR technique. Medical record audits with scores below 90% will identify the need for of repeat staff education. This particular facility is accredited by the National Commission on Correctional Health (NCCHC, 2018). Standard J-A-06 Continuous Quality Improvement is considered an essential standard therefore indicating the necessity to complete a minimum of two site annual specific quality improvement projects. Auditing and monitoring the staff for the efficacy of cell-side end-of shift reporting in conjunction with random medical record audits would satisfy 50% of this standard.

Cell-side end-of-shift SBAR reporting with patient inclusivity promotes positive social, accountability, and continuity of care when transitioning into the community health care system.

Contribution of the Doctoral Project Team

Correctional health care is a unique arena particularly for nurses. Having worked in correctional health as a staff nurse, director of nursing, and the health services

administrator with a background in nursing education, a knowledge deficit was identified in the end-of-shift reporting of infirmary patients at a local detention center. The main objective of this project was to improve the quality of care through education of the nursing staff on cell-side, end-of shift reporting utilizing the SBAR method. There is a gap in the literature that speaks to shift reporting when caring for detainees, and no current standards address a method of congruency in the transfer of patient information for end-of-shift reporting. The hope is this education project will be implemented and monitored for efficacy and may be disseminated and utilized in all the medical vendors contracted detention facilities with infirmary level care.

Strengths and Limitations of the Project

The strengths and limitations of this DNP project are both the population size of the participants. The benefit of a small population allows for the personalization and individualization in the educational component of the project. One hundred percent of the nursing staff was able and willing to participate in the educational project in order to enhance the end-of-shift reporting process. Another strength to be noted was the facility, and administrative support for the educational project. The organizational philosophy is to provide safe, quality, and efficient health care despite the fact of it being a detention center.

Section 5: Dissemination Plan

Clinical changes can be transformed into practice using a two-stage process (Stevens, 2005). The first stage includes translation of evidence and practice. Through nursing education, the practice change was summarized using evidence from data collection, observations, and a review of the literature. The cumulative information translated into this DNP project to improve the communication, consistency, congruency, and quality of patient information transfer during end-of-shift reporting at cell-side for patient inmates at a correctional facility. According to Stevens (2005), the second stage of the process involves integration of these recommendations into actual practice. Dissemination of the educational project staff evaluation results will occur at the next facility scheduled staff meeting. The department administration along with the medical vendor will determine if the practice change will be implemented.

Analysis of Self

IOM's (2010) emphasized the need to transform nursing education, particularly the DNP nurse. According to Giardino et al. (2020), doctoral prepared nurses acquire terminal degrees and are expected to practice at the highest level to impact health care in clinical practice, leadership, quality improvement, and health policy. My academic journey began in 2008 after a life-altering event. The expectation at that time was not to excel past a bachelor's degree, two master's degrees, a DNP, and 14 years of continued education. I have committed to lifelong learning. Aside from advanced education, many experiential lessons have been acquired along the way—not always pleasant but always a lesson. Early in my academic journey, I was introduced to Brookfield's (2005) becoming

a critically reflective teacher. Understanding how to critically reflect on situations aside from my previous role as a nurse educator has provided clarity in areas professionally and personally. The ability to heighten the skill of reflective thinking has been a major component of the success of my academic career. Each clinical environment presents gaps in practice, and although it is crucial to focus on the DNP essentials and organizational outcomes, success is dependent on the support of educational leaders, mentors, colleagues, and family to achieve the final outcome: program completion.

Summary

A gap in patient care was identified within a correctional facility. The gap in patient care was proven to impact patient information transfer, off-site referrals, and missed provider orders. Noted deficiencies emphasized the need for staff education to decrease the inconsistency and miscommunication of imperative patient information during nurse handoff. The purpose of this project was to educate nursing staff on the importance of using a standardized communication tool during cell-to-cell end-of-shift reporting. According to Tobiano et al. (2017), conceptualizing bedside handoff improves the transfer of information, improving efficiency, accountability, and overall patient safety. Utilizing the SBAR technique during end-of-shift patient information transfer, to be completed at cell-side, will decrease deficiencies in health care provider orders while involving the patient in care delivery.

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Appendix A: Staff Education Program

Objectives	Content	
Identify nature and causes of communication breakdown in the patient information transfer during end-of-shift reporting		
Define SBAR communication at the cell-side		
Identify the benefits of using the SBAR method to improve patient information transfer during end-of-shift report and enhance quality of patient care at the cell-side		

Appendix B: Staff Education Evaluation Form

As a learner please assist in the evaluation of this presentation. Please circle the number beside each statement that best reflects the extent of your agreement. Thank you.

		Disagree			Agree	
Content						
1.	The content was interesting to me.....	1	2	3	4	5
2.	The content extended my knowledge of the topic.....	1	2	3	4	5
3.	The content was consistent with the objectives.....	1	2	3	4	5
4.	The content was related to my job.....	1	2	3	4	5
5.	Objectives were consistent with purpose/goals of activity.....	1	2	3	4	5
Setting						
1.	The platform was conducive to learning.....		1	2	4	5
2.	The learning environment stimulated idea exchange.....	1	2	3	4	5
3.	Facility was appropriate for the activity.....	1	2	3	4	5
Faculty/Presenter Effectiveness						
1.	The presentation was clear and to the point.....	1	2	3	4	5
2.	The presenter demonstrated mastery of the topic.....	1	2	3	4	5
3.	The method used to present the material held my attention.....	1	2	3	4	5
4.	The presenter was responsive to participant concerns.....	1	2	3	4	5
Instructional Methods						
1.	The instructional material was well organized.....	1	2	3	4	5
2.	The instructional methods illustrated the concepts well.....	1	2	3	4	5
3.	The handout materials given are likely to be used as a future reference.....	1	2	3	4	5
4.	The teaching strategies were appropriate for the activity.....	1	2	3	4	5
Program Objectives						
1.	Identify nature and causes of communication breakdown in the patient information transfer during end-of-shift reporting...	1	2	3	4	5
2.	Define SBAR communication at the cell-side……	1	2	3	4	5
3.	Identify the benefits of using the SBAR method to improve patient information transfer during end-of-shift report and enhance quality of patient care at the cell-side……	1	2	3	4	5