

12-31-2025

## Staff Education to Improve patient outcomes Through Bedside Shift Report in a Skilled Nursing Facility

Ngum Avwontom  
*Walden University*

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>



Part of the [Nursing Commons](#)

---

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact [ScholarWorks@waldenu.edu](mailto:ScholarWorks@waldenu.edu).

# Walden University

College of Nursing

This is to certify that the doctoral study by

Ngum Avwontom

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.

Review Committee

Dr. Caroline Combs, Committee Chairperson, Nursing Faculty  
Dr. Diane Whitehead, Committee Member, Nursing Faculty

Chief Academic Officer and Provost  
Sue Subocz, Ph.D.

Walden University  
2025

Executive Summary: Staff Education Project  
Staff Education to Improve Patient Outcomes Through Bedside Shift Report in a Skilled  
Nursing Facility  
by  
Ngum Avwontom

MS, Bradley University, 2020

BS, Coppin University, 2014

Executive Summary Submitted in Partial Fulfillment of  
the Requirements for the Degree of  
Doctor of Nursing Practice

Walden University

November 2025

## Summary

Communication gaps during shift changes can lead to adverse outcomes, including medical errors, patient falls, and pressure ulcers. Bedside shift reports (BSRs) have emerged as a patient-centered strategy to strengthen handoff communication. The guiding question was: In a SNF, how does the implementation of BSR, compared to traditional shift reporting, affect the quality of patient care outcomes? Despite the proven benefits of BSRs, inconsistent implementation at the project site contributed to project breakdown and adverse events. Participants included registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) Quantitative data were analyzed using descriptive statistics and paired T-tests, while thematic analysis was employed for qualitative data. Eighteen staff completed training. Participant knowledge of BSR increased significantly from 67.8% on the pretest to 97.3% ( $p = .001$ ) on the posttest. Average shift report duration decreased from 5.4 to 3.67 minutes ( $p = .047$ ). Medical errors decreased from 1.3% to 0.4% and falls reduced from 5 to 2 per 1,000 patient days. Pressure ulcer rates remained unchanged. Nurse and patient satisfaction were high (93.7% and 95.4%, respectively). These results suggest that BSR enhances nursing practice by improving communication, reducing errors, and increasing efficiency. The intervention promotes patient-centered care, fosters trust, and supports equitable and inclusive communication, thereby empowering diverse patients and families to participate in care decisions. This initiative supports the national focus on patient-centered communication and aligns with the Agency for Healthcare Research and Quality's emphasis on standardized handoff practices.

## **Background**

Effective communication among nurses during shift changes is crucial for patient safety and continuation of care (Atinga et al., 2024; Chien et al., 2022; El-Sayed Ghonem & El-Husany, 2023; Kim et al., 2021). According to Atinga et al. (2024), communication gaps among healthcare providers during clinical shifts significantly contribute to adverse care and treatment outcomes. Communication breakdowns during shift reports can be attributed to different factors, including attitudinal factors (e.g., poor work ethics, inadequate documentation, interpersonal conflicts, and the use of unconventional language) and organizational factors, such as limited training opportunities and the absence of formal handover communication procedures and tools (Atinga et al., 2024).

Policy-driven initiatives emphasized patient-centered models of care, leading many hospitals to relocate handover practices from staff-only spaces to the patient's bedside (Chien et al., 2022). While much of the BSR evidence originates in acute care, similar principles apply to SNFs, where handoff communication amongst multidisciplinary teams is equally critical to continuity of care and resident safety (The Joint Commission, 2024). Despite these reforms, analyses of bedside handovers indicate that nurses frequently encounter difficulties in managing the complex communication demands during shift reports (Chien et al., 2022). The practice gap identified at the project site was the inconsistent implementation and utilization of BSR among nurses. This inconsistency led to communication breakdowns among healthcare providers and consequently increased the risk of adverse events, such as patient falls, medical errors, and pressure ulcers. The purpose of this staff education project was to improve patient

care outcomes by educating nurses about BSRs. The project question that guided this project was: In a skilled nursing home setting, how does the implementation of the BSR, compared to the traditional shift reporting, affect the quality of patient care outcomes?

According to Johns Hopkins Evidence-Based Practice (JHNEBP) model, which refers to the level or strength of the evidence, Sufficient Level II (Quasi-experimental Studies) and Level III (Non-experimental Studies) evidence support the benefits of BSR in decreasing medical errors, fall rates, pressure ulcers, and the duration of shift reports. Gregory et al. (2014). Training nurses about shift reports is effective in improving handoff knowledge and practices. In a quasi-experimental study, El-Sayed Ghonem & ElHusany (2023) found that the shift report training program significantly increased nurses' knowledge from 4.8% to 92.8% ( $p < .001$ ), adequate practice was achieved at 100%, and their perceptions of the process demonstrated significant improvement ( $p < .001$ ). Similarly, Ghasemi et al. (2025) conducted a quasi-experimental study to evaluate the impacts of educating nurses on the I Pass Baton communication model on patient safety culture. After the 2-week intervention, the intervention group demonstrated significant improvements across specific dimensions when compared with the control group, including a general understanding of patient safety ( $p = 0.002$ ), communication and feedback regarding errors ( $p = 0.039$ ), and management support for patient safety ( $p = 0.002$ ; Ghasemi et al., 2025). In a systematic review, Choi et al. (2023) found that educational interventions aimed at improving nursing shift handovers were effective in enhancing knowledge, performance, and self-efficacy, particularly when feedback was provided and participants received multiple practice opportunities. These studies

demonstrate that structured communication tools and educational interventions improve both the accuracy and efficiency of handovers, leading to safer and improved patient care outcomes.

In this project, I used the situation-background-assessment-recommendation (SBAR) communication framework as a fundamental tool to structure the BSR. The SBAR framework provides a standardized, predictable format for handover communication, ensuring that critical patient information is conveyed clearly and consistently between nurses. During the education intervention, nurses were trained to structure their reports using the SBAR technique, outlining the patient's immediate situation and relevant background history as well as the nurse's current assessment and clear recommendations for the oncoming shift.

### **Staff Education Project Development**

This staff education project took place in a 100-bed SNF over a 7-week period in four phases to develop, implement, and evaluate a standardized BSR program. I measured the outcomes for this project at multiple time points to capture both its immediate and sustained effects. A baseline assessment was conducted during Phase 1 (Week 1) to establish the pre-intervention rates of key metrics, such as patient falls and pressure ulcers. Preliminary data were then collected during Phase 2 pilot (Week 2) for initial feedback. A formal post-implementation evaluation took place during Phase 3 (Weeks 3–6) following the facility-wide rollout, with ongoing monitoring planned for Phase 4 to assess long-term sustainability. To ensure data accuracy, I employed a multipronged approach. The use of standardized checklists during the BSR process

promoted consistent and complete documentation. Furthermore, data were collected from the facility's verified incident reporting system for objective outcomes, like falls and pressure ulcers, which are routinely tracked and audited for compliance. This combination of tools and systems helped ensure the data collected for evaluation were both reliable and valid.

Participants in the project included full-time and part-time RNs, LPNs, CNAs, patients, family members, and administrative leaders. RNs were primarily responsible for conducting BSRs and documenting outcomes, while LPNs and CNAs participated by contributing direct care updates and supporting the handoff process. Patients who were cognitively able engaged actively in bedside discussions, while family members were invited to provide feedback on communication and care transitions during the full rollout phase. Nursing home administrators and medical directors supported implementation by reviewing outcomes, approving training resources, and reinforcing compliance among staff.

Data collected related to both clinical outcomes and staff/patient experiences. Safety outcomes included medication errors, fall rates, and new pressure ulcer incidents. Safety data were collected from pharmacy reports, incident logs, and wound care documentation. The operational outcome was measured by the average duration of shift reports, as recorded in time logs. I assessed nurse satisfaction and perceptions using surveys and focus groups, while patient and family satisfaction was evaluated through short post-BSR questionnaires. Process outcomes were monitored through audit logs

documenting BSR compliance, pre- and post-training knowledge assessments, and competency validation forms. The sustainability of the project will be evaluated at 3 and 6 months following its completion.

The data were analyzed using both quantitative and qualitative methods. I summarized quantitative outcomes using descriptive statistics. The pre- and postimplementation comparisons were conducted to assess changes in medical errors, falls, pressure ulcers, and shift report duration. Descriptive statistics used included means, frequencies, and percentages. I conducted paired samples T-tests to assess the changes in shift duration and staff's knowledge before and after the implementation of the intervention. Qualitative data from surveys and focus groups were analyzed thematically.

### **Results**

A total of 18 healthcare staff members were trained on BSR and completed the pre- and post-test knowledge assessments. The results showed a statistically significant increase in staff knowledge of BSR, from a mean of 67.8% to 97.3% ( $t = 6.12, p = .001$ ). Similarly, there was a statistically significant decrease in shift duration from a mean of 5.4 minutes to 3.67 minutes ( $t = 2.1, p = .047$ ). The rate of medical errors 1 month before the implementation was 1.3%, which decreased to 0.4% 1 month following the implementation of the intervention. Similarly, the rate of patient falls decreased from 5 to 2 per 1,000 patient days. However, there were no notable changes in the incidences of pressure ulcers, which remained at two incidences 2 months before and after the implementation of the intervention. Nurses and patients expressed positive perceptions about BSR and were satisfied with the intervention (i.e., they reported average

satisfaction of 93.7% and 95.4% respectively). No data were collected from family members to explore their perceptions or satisfaction. Overall, there was a high rate of compliance with the BSR report throughout the implementation after the training (98.6%).

The findings of this project demonstrate the important benefits of implementing standardized BSR in a SNF. The significant improvement in staff knowledge, from 67.8% to 97.3%, highlights the effectiveness of structured training in enhancing healthcare staff's knowledge and competencies to provide quality and safe care to patients, based on current and emerging evidence-based practices. The reduction in shift report duration from 5.4 to 3.67 minutes indicates an enhanced efficiency in healthcare facility operations. Shorter and more structured handoffs improve workflow efficiency without compromising the quality of care. Efficiency is crucial in healthcare settings, such as a SNFs, where staffing resources are often limited and timely care delivery is critical (Mbaw et al., 2022).

The decline in medical errors (1.3% to 0.4%) and patient falls (from 5 to 2 per 1,000 patient days) indicates a positive clinical impact of improved communication and situational awareness facilitated by BSR. These improvements underscore the importance of streamlining shift report communications to decrease preventable adverse events, such as patient falls and medical errors, which are a crucial safety metric for the quality of care provided. The decrease in medical errors and patient falls improves the setting's safety score. The high satisfaction scores of both nurses (93.7%) and patients (95.4%) demonstrate that the intervention was well received and perceived as beneficial. High

satisfaction with the intervention will enhance its compliance and sustainment efforts, which will improve the long-term benefits of the intervention at the facility.

Several limitations should be considered when applying and generalizing the results of this project. The project was conducted in a single SNF, which may limit the generalizability of the findings to other long-term care settings with different staffing levels or organizational cultures. The evaluation period was relatively short, capturing outcomes only within the first months of implementation; therefore, the long-term sustainability of improvements was not assessed. I did not collect family perspectives, which limited understanding of their role in enhancing communication and care transitions in this context. Finally, reliance on self-reported surveys for nurse and patient satisfaction may have introduced response bias.

The project was initiated to address a critical gap in clinical practice. Inconsistent and nonstandardized communication during nursing shift changes (i.e., handoffs) was identified as a root cause of preventable adverse events. This lack of a reliable process created vulnerabilities in patient care.

A BSR is an evidence-based practice where the shift handoff is conducted at the patient's bedside. This involves the outgoing nurse, the incoming nurse, and the patient/family, promoting transparency and patient involvement. The SBAR framework is a structured communication tool used to standardize the handoff process. The use of the framework ensures that critical information is conveyed clearly, concisely, and predictably, thereby reducing the likelihood of omissions or misunderstandings.

The p-values ( $P = .001$ ,  $p = .047$ ) indicate that the observed improvements in staff knowledge and report efficiency are statistically significant. This means there is a very low probability (less than 1% and 4.7% chance, respectively) that these results occurred by random chance, strengthening the evidence that the intervention itself caused the improvements.

I assessed multiple outcome metrics for this project. The medical error rate is calculated as a percentage of total opportunities for error (e.g., medication administration), while the falls rate is expressed as the number of falls per 1,000 patient days. This is a standard metric that enables comparison across units and facilities by taking into account patient volume. I measured satisfaction through post-intervention surveys administered to staff and patients, indicating high acceptability of the new process. This initiative aligns with national goals and directly supports the priorities of leading healthcare quality organizations, such as the Agency for Healthcare Research and Quality and The Joint Commission, that emphasize standardized handoff communication and patient-centered care as critical to improving safety and quality.

In the project, I noted that pressure ulcer rates were unaffected, suggesting BSR alone is insufficient for this specific outcome. Therefore, future efforts should integrate BSR with targeted, evidence-based pressure ulcer prevention bundles. The short implementation period also necessitates a focus on long-term sustainability to ensure gains are maintained.

## **Conclusions**

The successful implementation of a standardized BSR program significantly enhanced communication, strengthened patient safety, and advanced patient-centered care within the SNF. This initiative led to measurable improvements, including a reduction in medical errors and patient falls, while also increasing the efficiency of shift handoffs. By equipping nurses with a structured communication tool, the project promoted greater accountability and empowered both patients and their families to participate in their care. These outcomes demonstrate that BSRs are a powerful practice for improving the quality, safety, and patient-centeredness of care in the long-term setting. Future efforts should focus on sustaining these gains, expanding the program to other facilities, and further integrating preventive strategies and family engagement to build upon this foundation. I recommend sustained follow-up beyond the initial implementation period to evaluate the long-term improvements in knowledge, efficiency, and safety outcomes. Additional interventions should be integrated to address outcomes, such as pressure ulcers, combining BSRs with targeted preventive strategies.

## References

- Atinga, R. A., Gmaligan, M. N., Ayawine, A., & Yambah, J. K. (2024). "It's the patient that suffers from poor communication": Analyzing communication gaps and associated consequences in handover events from nurses' experiences. *SSM - Qualitative Research in Health*, 6, 100482.  
<https://doi.org/10.1016/j.ssmqr.2024.100482>
- Chien, L. J., Slade, D., Dahm, M. R., Brady, B., Roberts, E., Goncharov, L., Taylor, J., Eggins, S., & Thornton, A. (2022). Improving patient-centred care through a tailored intervention addressing nursing clinical handover communication in its organizational and cultural context. *Journal of Advanced Nursing*, 78(5), 1413-1430. <https://doi.org/10.1111/jan.15110>
- Choi, J. Y., Byun, M., & Kim, E. J. (2023). Educational interventions for improving nursing shift handovers: A systematic review. *Nurse Education in Practice*, 74, 103846. <https://doi.org/10.1016/j.nepr.2023.103846>
- El-Sayed Ghonem, N. M., & El-Husany, W. A. (2023). SBAR shift report training program and its effect on nurses' knowledge and practice and their perception of shift handoff communication. *SAGE Open Nursing*, 9, 23779608231159340.  
<https://doi.org/10.1177/23779608231159340>

- Ghasemi, A., Sadeghi, T., Jamali, J., Pourghaznein, T., & Behbodi Far, A. (2025). Effect of an educational program based on a standardized handoff communication model of I Pass Baton to nurses in the process of shift Handoff on patient safety culture: A quasi-experimental study. *Journal of Nursing Reports in Clinical Practice*, 3(5), 443-452. [https://www.jnursrcp.com/article\\_217845.html](https://www.jnursrcp.com/article_217845.html)
- Gregory, S., Tan, D., Tilrico, M., Edwardson, N., & Gamm, L. (2014). Does bedside shift Report improve patient safety? *The Journal of Nursing Administration*, 44(10), 541–546. <https://doi.org/10.1097/NNA.0000000000000115>
- Kim, J. H., Lee, J. L., & Kim, E. M. (2021). Patient safety culture and handoff evaluation of nurses in small and medium-sized hospitals. *International Journal of Nursing Sciences*, 8(1), 58-64. <https://doi.org/10.1016/j.ijnss.2020.12.007>
- Mbau, R., Musiega, A., Nyawira, L., Tsofa, B., Mulwa, A., Molyneux, S., Maina, I., Jemutai, J., Normand, C., Hanson, K., & Barasa, E. (2022). Analysing the efficiency of health systems: A systematic review of the literature. *Applied Health Economics and Health Policy*, 21(2), 205. <https://doi.org/10.1007/s40258-022-00785-2>
- The Joint Commission. (2024). *National Patient Safety Goal (NPSG) chapter for nursing care center accreditation program*. <https://www.jointcommission.org/standards/national-patient-safety-goals/nursingcare-center-national-patient-safety-goals/>