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Implementing Bedside Shift Report: An Evaluation of Change in Practice

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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
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Abstract

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MSN, Walden University, 2013

BSN, Nova Southeastern University, 2007

Project Submitted in Partial Fulfillment

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Abstract

Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) survey results from 2013 revealed a need for improvement in nurse-patient communication at the unit level. In response, nursing administrators at an acute-care hospital asked bedside nurses to develop a protocol for bedside shift report according to best practices. The protocol was implemented in May 2014. Three months later, a postimplementation survey was distributed. Work from Lewin and Kotter theoretical concepts were used to evaluate this organizational change. The purpose of this study was to determine whether re-educating staff nurses on the bedside shift report protocol increased compliance with evidence-based practice performance standards for bedside shift reporting. In the initial phase of this project, a review of a 3-month postimplementation survey revealed consensus that bedside shift report had not been universally accepted and implemented. Based on these findings, a re-education program was developed and implemented. A 2-week post re-education survey elicited 89 respondents' perspectives on bedside shift report. Analysis of the survey results revealed that nurses had strong perceptions of this significant change to their practice. The re-education revealed that nurses could show commitment to performing daily bedside shift report if specific conditions are supported, such as nurses understanding that the process improves satisfaction levels, and if nurses' misconceptions are addressed. Social change of this magnitude indicated that the voices of bedside nurses must be heard. To make this goal a reality ongoing evaluation is required to promote patient safety, improve patient outcomes, and improve HCAHPS results related to nurse-patient communication. Positive social change results in this project impacting patients by providing a better quality of care in this facility.

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Dedication

I would like to dedicate this paper to all the frontline nurses who provide compassionate care to all the patients they serve every day. I would also like to acknowledge their dedication, commitment, and tireless efforts to provide safe, quality care in a technology-laden, ever-changing health care environment.

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I would like to acknowledge Dr. Theresa Morrison, for the support she has given me throughout my DNP journey and all of my Walden University professors, especially Dr. Wilson and Dr. Beene, for their gentle guidance during the completion of my paper. Most of all, I would like to acknowledge my daughter, Toni Palumbo, for her continued support, encouragement, and patience as I pursued a doctoral nursing degree.

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Section 1: Overview of the Evidence-Based Project

Introduction

A bedside shift report protocol has been successfully implemented in many hospital settings. *Bedside shift report*, a process whereby a nurse completing a 12-hour shift and a nurse arriving for a 12-hour shift transfer information related to safe and effective care in the presence of the patient, prevents adverse events and medical errors (Cairns, Dudjak, Hoffman, & Lorenz, 2013; Carlson, 2013; Hagman, Mona, Kleiner, Johnson, & Nordhagen, 2013; Maxson, Derby, Wrobliski, & Foss, 2012; Randell, Wilson, & Woodward, 2011). Nurse bedside shift report helps ensure the safe handoff of care between nurses by involving the patient and family (U.S. Department of Health and Human Services [HHS], n.d.).

The bedside shift report protocol was a quality improvement project to improve patient care and outcomes as well as raise patient satisfaction. Nurses at the study site aimed to provide safe, patient-centered care of the highest quality, yet the site's Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) survey scores were below the national average. HCAHPS provides a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care (HCAHPS, 2014). The HCAHPS survey, which is also known as the CAHPS® Hospital Survey, or Hospital CAHPS, is a core set of questions, one of which involves patient perspectives on nurse-patient communication. Today's health care environment is ever changing in response to governmental regulations, increased consumer expectations, and advances in technology, which add to the daily responsibilities associated with bedside care. One of the 2011 National Patient Safety Goals established by the Joint Commission

and mentioned in the Institute of Medicine (IOM) executive summary entitled "A Bridge to Quality" is patient-centered care. Bedside shift report fits with the IOM's statement that communication ensures patient-centered care when evidence-based practices are used.

Problem Statement

HCAHPS survey results for 2013 revealed a need for improvement at the unit level in nurse-patient communication at the study site. In response, nursing administrators asked bedside nurses to develop a protocol for bedside shift report according to best practices. The premise underlying the implementation of bedside shift report was that moving handoff shift reporting to the bedside would improve patient satisfaction scores by improving (a) patient safety and quality, (b) patient experience of care, (c) nursing staff satisfaction, and (d) time management and accountability between nurses (Agency for Healthcare Research and Quality [AHRQ], 2013). The protocol was implemented in May 2014. Three months later, a postimplementation survey was distributed. See Appendix A. The survey was not analyzed, but the consensus was that bedside shift report had not been universally accepted and implemented. Gregory, Tan, Tilrico, Edwardson, and Gamm's (2014) systematic review of the literature on bedside shift report noted, "Nurses continue to not recognize the evidence supporting this practice and adopt bedside report into practice" (p. 541). In the value-based healthcare environment, improving patient safety and satisfaction is a financial imperative related to Medicare reimbursement. As discussed by Reinbeck and Fitzsimons (2013), organizations must focus on safety as well as effective communication strategies that promote patient satisfaction and patients' engagement in their care. The implementation

of bedside report is an initiative to deliver enhanced patient experiences and raise HCAPHS scores. Communication during change-of-shift is essential to ensure that the handoff is safe and effective and that it engages the patient. However, implementing evidence-based research into practice is often challenging.

The problem with organizational implementation of bedside shift report is related to the education of nursing staff and implementation at the bedside to effect a change to practice. In order for this change related to unit-level outcomes of care to be a success, direct care providers must stay engaged in the process. Greater compliance with the change and increased staff accountability are related to unit leadership commitment and program evaluation (Hagman et al., 2013). White and Dudley-Brown (2012) discussed the importance of effective communication of goals of the organization related to positive outcomes and benefits to those involved with a change. A greater understanding of nurses' satisfaction with the practice change to move shift report to the bedside is essential for program sustainability.

Purpose Statement

The purpose of this project was to determine whether re-educating staff nurses on the bedside shift report protocol would increase the acceptance of the change in practice for staff nurses and increase the incidence of compliance based on the post re-education survey.

Project Objectives

The initial phase of this project involved reviewing the 3-month postimplementation survey. From these findings, a re-education program was developed and implemented, and a 3-month post re-education assessment was conducted using the

same survey. The intent of the survey was to determine the effect of the newly instituted bedside shift report process from the bedside nurses' perspective. After analysis of the initial survey results, insights gained concerning nurses' perceptions of the significant change to the practice of change-of-shift reporting guided the re-education effort.

The goal of re-education concerning the bedside shift report protocol was to improve the implementation process and increase staff compliance. The objective of analyzing the initial 3-month postimplementation survey results was to develop a re-education program based on nurses' responses about bedside shift reporting. The objective of analyzing the re-education survey results was to determine whether performance had improved and whether barriers remained.

Significance of the Project

Assessment of a change in practice related to the transition to bedside nurse shift handoffs is essential (Gregory, Tan, Tilrico, Edwardson, & Gamm, 2014; McMurray et al., 2010; Olson-Stiki, Weitzel, & Gilsson, 2013). To evaluate the success of the change in practice is to assess how nurses view the change (Radtke, 2013). The organization initiated the change to bedside shift report in response to an attempt to raise patient satisfaction HCAHPS nursing communication scores. There is a plethora of evidence to support the positive impact of bedside shift report in the areas of patient safety, satisfaction, pain control, and nurse-patient as well as nurse-to-nurse communication (Chaboyer, McMurray, Johnson, Hardy, & Wallis, 2009; Dempsey, Reilly, & Buhlman, 2014; Dufault et al., 2010). Patient satisfaction scores associated with nursing-sensitive indicators related to communication were identified as an area for improvement at this

acute care hospital. Based on patient surveys after discharge, communication with the nurse during the hospital stay was an area identified for improvement.

Project Question

Will assisting the organization in evaluating the current bedside shift report process**,** in re-educating staff, and in reimplementing bedside shift report change what nurses think about the process? After analysis of the initial survey, a re-education program was developed, and a post re-education survey was conducted.

Significance of the Project

Implementation of bedside shift report is significant to the organization as a means to provide a cutting-edge, patient-centric innovation at the bedside. The use of evidence-based practice is essential to the hospital's efforts to provide optimal patient care and remain one of the area's facilities recognized for promoting excellence in nursing care, which yields organizational benefits related to hospital choice among consumers of healthcare (HHS, n.d.). Healthcare organizations have a responsibility to ensure that the care provided to the patients they serve is current and research based. The adage "that is the way things have always been done" is no longer acceptable as providers strive to deliver quality, safe care to those whose health is entrusted to them (White & Dudley-Brown, 2012, p. 175).

The implementation of bedside shift report increases patient and family satisfaction (Gregory, Tan, Tilrico, Edwardson, & Gamm, 2014; McMurray et al., 2010; Olson-Stiki, Weitzel, & Gilsson, 2013; Sand-Jecklin & Sherman, 2012). The initiative to move change of shift nurse-to-nurse report to the bedside is a significant change in

practice. Prior to the change to bedside shift report, the reporting method included reports being given at the nursing station or in conference rooms on the nursing units.

Reduction of Gaps

Buy-in from end users is essential to a program's success. Organizational change management strategies are critical to a program's implementation process and sustainability. Wakefield, Ragan, Brandt, and Tregnango (2012) emphasized this point, noting that the transition to bedside shift report requires extensive planning, education of nursing staff, and gradual implementation for program acceptance. Program evaluation is essential to ensure the program's sustainability and consistent nurse compliance with the change. Hodges and Videto (2011) discussed program evaluation as a means to measure program outcomes and the need for improvement. This project assisted in identifying gaps in knowledge related to nurses' compliance and comfort level with the implementation of bedside shift report and the implementation process itself.

Implications for Social Change

For a DNP graduate, the ability to influence positive social change is imperative. At the hospital where this project was conducted, program evaluation related to the implementation of bedside shift report regarding staff nurse compliance with this practice change was necessary to ensure that the aim of the change was realized. Principal activities of the DNP-prepared practitioner include the translation of evidence into practice, application, and evaluation (American Association of Colleges of Nursing [AACN], 2006). Essential III is related to scholarship for evidence-based practice. This program evaluation related to the implementation of bedside shift report may assist similar facilities in implementing unit-level changes.

The DNP nurse's responsibility is to provide leadership to train others and ensure the sustainability of programs. It is the responsibility of the DNP practitioner to offer others positive support related to change and to promote lifelong learning. The DNP practitioner must be passionate about social change and advancing the greater global good. In addition, the DNP practitioner's responsibility to the organization is to recommend resources to lead a culture structured by psychological and systems safety (Zaccagnini & White, 2011).

The change to bedside shift report is an evidence-based model for nursing handoff shift reporting (HHS, n.d.). Information on nurse training, implementation, and evaluation concerning the change in practice to bedside shift report may provide the profession with a standardized method for reporting. The purpose of bedside shift report is to ensure patient safety through the passage of thorough, relevant information from one nurse to another. In addition, during bedside shift report, the patient and/or family are brought into the conversation. Patient and family engagement is essential to the bedside shift report process to ensure that pertinent information is not missed and that the patient is active in the decision-making process related to the plan of care. In response to consumer demands, healthcare institutions have become more transparent and accountable to stakeholders to achieve desired patient outcomes.

In the organization's effort to improve patient outcomes, a variety of strategies must be employed to ensure that change is taking place at the unit level. Wachter and Pronovost (2009) stated that an environment of change promotion should not be punitive or blaming. Rather, the environment should foster an atmosphere focused on patient-centered care, evidence-based practice, and a desire to provide excellence and

acknowledge professionalism in nursing care. The implementation of bedside shift report is an organizational initiative to provide up-to-date, evidence-based nursing care and improve patient satisfaction scores in the area of nursing communication.

One area of responsibility on the part of the organization is to provide adequate training for the direct care nursing staff responsible for those patient outcomes. The nurses were assigned a computer-based training module, managers were instructed to review the protocol during monthly staff meetings, and question-and-answer and tip sheets were handed out. However, the change came upon the staff suddenly and unexpectedly. With over 2,000 nurses to train, the methods did not appear to be adequate.

A just-do-it method is not sufficient for eliciting support for a practice change of this magnitude (Radtke, 2013). Organizational support for "upward voice" (Edmonson, as cited in Zaccagnini & White, 2011) is necessary to promote a culture of psychological safety. Edmonson described "upward voice" as communication that is directed to someone in a position higher in the organizational hierarchy with authority to address the stated problem and take action. McMurry, Chaboyer, Wallis, and Fetherston (2010) proposed that nurses, as a rule, are supportive of quality improvement initiatives, especially those with a focus on standardization of care. The successful implementation of bedside shift report was contingent upon managerial assessment of nurses' attitudes, motivation, and concerns related to a change in practice as significant as moving change of shift report to the bedside. The survey illuminated the deficiencies in the training that had been designed to enable re-education and the success of bedside shift reporting.

Definition of Terms

Bedside nurse: The term is synonymous with *direct care nurse* or *staff nurse*.

Bedside shift report: The term is synonymous with several terms, including *report*, *shift report*, *change of shift*, and *handoff-communication*. *Report* is the transfer of information, responsibility, and care of the patient from one nurse to another (Griffin, 2010). *Bedside report* is the approach of exchanging patient information in the presence of the patient, which provides an opportunity for the patient to be engaged in the report and ask questions (HHS, n.d.).

Change–of-shift: This is a time for report between the off-going and oncoming nurse when responsibility and accountability for care of the patient are transferred from one nurse to another (Griffin, 2010).

Communication: For the purpose of this project, communication refers to the transfer of vital patient information from one caregiver to another (Reinbeck & Fitzsimons, 2013).

HCAHPS scores: HCAHPS is a survey used by hospitals to assess patients' experience during their hospital stay (Radtke, 2013). For the purpose of this study, the area of focus is communication between nurses and patients and their families.

Patient-centered care: Patient-centered care is defined as care planned through collaboration with the healthcare team and the patient. The patient has an active part in the process and understanding related to decisions in the care provided to him or her (Chaboyer, Johnson, Hardy, Gehrke, & Panuwatwanich, 2010).

Patient engagement: "The actions people take for their health and to benefit from health care" (Gruman, 2013, p. 428). Patient engagement takes place when health care professionals support patients in the decision-making process related to their health care.

Situation-background-assessment-recommendation (SBAR): The mnemonic SBAR is a structured process to facilitate communications among the members of a health care team, which ensures a standardized format to relay essential information during bedside shift report (Welsh, Flanagan, & Ebright, 2010).

Standardization: For the purposes of this project, standardization refers to relaying information during nurse-to-nurse handoffs using a systematic approach (Costedio, Powers, & Stuart, 2013).

Assumptions and Limitations

The overreaching assumption of this project was that the nursing staff at this acute care facility was motivated to increase patient satisfaction scores through the implementation of bedside shift reporting. The direct care nursing staff's awareness and education related to the change were necessary for acceptance of the implementation of bedside shift reporting, which was a significant change in practice, as well as for the project to yield favorable outcomes.

The limitations to this study included self-reporting related to nurses' compliance in consistently performing bedside shift reporting. Concern related to self-reporting of compliance with the change to bedside shift report derived from the fact that noncompliance results in disciplinary action at this time in the implementation process.

Summary

This project was developed to determine whether re-educating staff nurses on the bedside shift report protocol would increase the incidence of compliance with evidence-based practice performance standards for bedside shift report. Implementation of bedside shift report was instituted to improve patient satisfaction scores related to the nurse-sensitive indicators of how well nurses communicate with patients during their hospitalization. Due to the organizational change to bedside shift report as part of an initiative to ensure that care practices are more patient centered, the primary outcome of interest was an increase in nurse compliance and satisfaction with the change. Also of interest was compliance of the nursing staff with the requirement to incorporate the evidence-based practice of bedside shift report into daily operations. Bedside shift report is a significant change in practice, and the support of nursing management and staff involvement are essential to the success of the change process.

Section 2: Review of Scholarly Evidence

Introduction

A methodical investigation of the literature was performed using Cumulative Index for Nursing and Allied Health Literature (CINAHL), PubMed, Ovid Nursing Journals Full Text, ProQuest, and Cochrane Database of Systematic Reviews. These search engines were explored using the terms *bedside report*, *handoff*, *handover*, *guidelines*, and *nurse*. Articles were evaluated for usefulness with respect to bedside shift report and complying with established protocols. Best-practice articles included information verifying the importance of bedside shift report and were included to identify the reasons staff would have issues with compliance.

The literature reviewed included the evolution of bedside shift report in the hospital setting and the theoretical frameworks for change in the clinical setting related to the initiation of bedside shift report as opposed to the traditional nurse-to-nurse change of shift report performed outside patient rooms. Extensive documentation was found regarding the implementation of bedside shift report. The Agency for Healthcare Research and Quality (AHRQ) collaborated with the Institute for Patient and Family-Centered Care, Consumers Advancing Patient Safety, the Joint Commission, and the Health Research and Educational Trust to develop the Nurse Bedside Shift Report (AHRQ, 2013)

A review of scholarly evidence provides clinical information to support the implementation of bedside shift report. A general literature review addresses issues related to the implementation process at the organizational level for program sustainability.

Specific Literature

This specific literature review addresses the evolution of the clinical practice change from a traditional nurse-to-nurse shift report, which occurs away from the bedside, to the implementation of bedside shift report. Bedside shift report is in direct alignment with the recommendation of the Nursing Alliance for Quality Care (NAQC; Sofaer & Schumann, 2013) to engage patients in their care. The Joint Commission (TJC), as a result of sentinel event reviews, identified handoffs between health care providers as a problem contributing to ineffective communication (Evans, Grunwalt, McClish, Wood, & Friese, 2012). The subsequent recommendation was that healthcare organizations implement a standardized method to communicate the change of shift report to include discussion, engagement, and opportunities to ask questions (Catalano, 2009).

Traditional change-of-shift report methods included verbal face-to-face, written, or tape-recorded reporting (Jeffes et al., 2013). Wolfe (1988) defined *shift-to-shift report* as an "occupational ritual" (as cited in Evans, 2012). The shift-to-shift report is a time when healthcare providers discuss critical patient information. In today's complex healthcare environment, effective communication during this time is essential to provide safe, high-quality care. Chaboyer et al. (2009) supported the observation that nurses do not always communicate well with their patients, which contributes to low patient satisfaction scores. Organizational improvements to change-of-shift reporting have resulted from TJC's emphasis on patient engagement and safety initiatives. Costedio, Powers, and Stuart (2013) discussed TJC's recommendation to standardize communication practices among health care practitioners during change-of-shift report.

Review of the literature indicates that bedside report is a way of increasing patient satisfaction as well as improving patient satisfaction scores (Jeffs et al., 2014), family perceptions (Tobiano, Chaboyer, & McMurray, 2012), and nurse satisfaction (Ferris, 2013). Additionally, the literature indicates that bedside report supports a patient-centered care model (Dean, 2009), increases staff accountability (Dempsey, Reilly, & Buhlam, 2014), increases patient safety (Currier, 2011), enhances documentation (Kerr, Lu, & McKinlay, 2013), and improves communication between staff members during shift report (Radtke, 2013). In the context of improving patient satisfaction scores, nursing is at the forefront of implementing changes to practice based on evidence.

The literature review on bedside shift report indicated that the majority of the literature available describes benefits of the change in practice toward implementing bedside shift report. The benefits discussed in the literature are numerous (Currier, 2011; Dean, 2009; Dempsey et al., 2014; Ferris, 2013; Jeffs et al., 2014; Kerr et al., 2013; Radtke, 2013; Tobiano et al., 2012). Griffin (2010) suggested that shift report may be a time to socialize and share information related to nurses' personal lives. The use of bedside shift report focuses the exchange of information about the patient, which makes it more relevant, objective, and concise. Bedside shift report may contribute to financial savings related to decreased adverse events regarding medication errors and falls that occur during the change of shift. Patients and families feel that bedside shift report is advantageous, as they are aware of whom their nurse is on every shift. Patient comments included "I do feel no one is watching me at shift change" (Tidwell et al., 2011). A common theme identified in the literature was support for the implementation of bedside

shift report to increase nurses' communication with patients and their families as well as each other.

General Literature

In my general literature review, I explored organizational change strategies related to the implementation of bedside shift report and nurses' perceptions related to this change. Effective implementation of bedside shift report requires staff training related to effective reporting. Providing the shift change report at the bedside is a skill that requires training, practice, evaluation, and feedback from management (Welsh, Flanagan, & Ebright, 2010). The literature related to change management in complex organizations, as discussed by Clark and Persuad (2012), indicates that resistance to change may be reduced by answering questions and providing feedback throughout the change process to ensure success. Lavoi et al. (2014) discussed the importance of communicating the rationale for change to the staff members involved in the change process. Wakefield, Ragan, Brandt, and Tregnago (2012) considered optimization of the process after implementation to include the need to assess the nursing staff's attitudes prior to and after the change. Periodic interventions may be necessary to embed the change in the culture of nursing.

The organization where the bedside shift report protocol was initiated is a "Most Wired" healthcare system. According to the results of the 2012 Most Wired Survey released in the July 2013 issue of *Hospitals & Health Networks* magazine, the setting for bedside shift report is conducive to an advanced electronic medical record (EMR) system. The advanced EMR system provides a standardized screen, which includes the situation-background-assessment-recommendation (SBAR) mnemonic. The SBAR

format was already in use during change of shift report away from the bedside, and the process would continue during bedside shift report. Staggers and Jennings's (2009) qualitative study found that efficiencies in report could be gained from EMR; themes emerged that can be used to improve a bedside report protocol. Change of shift EMR templates can enhance and sustain improvement in bedside shift report (Nelson & Massey, 2010).

Research indicates that other facilities may have experienced negative results related to the change to bedside shift report that are not reflected in the published literature. Health care leaders may view unsuccessful application as a personal failure versus an inherent problem with the process of bedside shift report and not include these findings in their reports (Sherman, Sand-Jecklin, & Johnson, 2013). Bedside shift-to-shift report is not a new concept within nursing and is acknowledged in the literature as an effective means for patient engagement (Grant & Colello, 2010). Organizations face several challenges related to this change in practice. Laws and Amato (2010) proposed that staff education is necessary to elicit buy-in from staff nurses. Nursing management support and encouragement are essential, especially in the beginning phases of the process due to high resistance during this phase.

Theoretical Frameworks

Implementation of bedside shift report is guided by Lewin's three-stage change theory along with Kotter's eight-step change model. In addition, Paplua's interpersonal relations theory may be applicable. Paplua's theory defines the relationship between nurse and patient as one that is therapeutic; is based on trust, mutual understanding, and communication; and fosters mutual goal setting (Radtke, 2013).

Lewin's Theory of Change

Lewin's theory of change has a foundation in social psychology. Lewin began his studies with an interest in behaviorism and later developed an interest in Gestalt psychology ("Kurt Lewin Biography," n.d.). Lewin's three-stage approach applied to organizational change is appropriate for the implementation of bedside shift report. Lewin's three-stage model includes the following:

1. Unfreezing the present position.
2. Moving to a new situation.
3. Refreezing in the new situation.

Parts 2 and 3 relate to the analysis of the initial survey findings, which assisted with the development of re-education and drove a change in the process of bedside shift report.

Lewin's model was applied to the necessary changes for bedside shift report to be successful (Hagman et al., 2013). The first phase involves confronting and challenging existing staff attitudes and beliefs toward bedside shift report. Phase 2 involves providing education to the staff regarding the process of bedside shift report introduction and implementation. In Phase 3, bedside shift report has been incorporated into daily practice (Vines, Dupler, Van Son, & Guido, 2014).

Kotter's Eight-Step Change Model

A predictor of success of the program is the involvement of those whom the change will affect. Kotter (as cited in McMurray, Chaboyer, Wallis, & Fetherston, 2010) discussed the largest obstacles organizations face related to change. The obstacles include failure to articulate the change in relation to rationale, time frame, and steps involved in the change process. Kotter, from the Harvard School of Business, is recognized as one of the most influential advocates for leadership and developed an eight-step model for change (McMurray, Chaboyer, Wallis, & Fetherston, 2010). Kotter's eight-step model includes the following:

1. Create a sense of urgency
2. Form a powerful coalition
3. Create a vision
4. Communicate the vision
5. Remove obstacles
6. Create short-term wins
7. Build on change
8. Anchor change in corporate culture (Zaccagnini & White, 2011).

Work by Lewin and Kotter may inform the development of models for change related to the implementation of bedside shift report.

Summary

Section 2 has presented a review of the literature describing the benefits of the change in practice related to the implementation of bedside shift report. The majority of the research supports the shift from a traditional change of shift report performed away

from the patient's bedside to bedside reporting. Benefits of patient engagement at change of shift report include increased safety, nurse accountability, and patient satisfaction. Lewin's theory of change and Kotter's eight-step change model were presented to guide the implementation of bedside shift report.

Section 3: Approach

Introduction

The purpose of this study was to determine whether re-educating staff nurses on the bedside shift report protocol would increase the incidence of compliance with evidence-based practice performance standards for this activity. The first phase of this project involved reviewing the 3-month post implementation survey (original survey). From these findings, a re-education program was developed and implemented, and a 3-month assessment using the same survey (second survey) was conducted. The intent of the original survey was to elicit information on the effect of the newly instituted bedside shift report process from the bedside nurses' perspective. The first phase, analysis of the original survey, was designed to provide insight into the nurses' perceptions of the significant change to the practice of change of shift report. This analysis guided the second phase of this project, which was the re-education of the nurses. This approach section presents the population and sampling methods, data collection strategies, and data analysis. Section 3 concludes with the project evaluation plan.

Project Design and Method

A mixed method involving both quantitative and qualitative data was appropriately used in this project due to the previous completed survey, which contained open-ended questions. Quantitative criteria were emphasized, but high-quality qualitative data were collected and analyzed. In this primarily quantitative study, qualitative data were analyzed to supplement and add deeper, fuller explanation to the project.

The bedside shift report protocol was a quality improvement project to improve patient care and outcomes, raise patient satisfaction, and increase HCAHPS survey scores. The nursing profession is changing to accommodate governmental regulations, increased consumer expectations, and advances in technology, which add to the daily responsibilities associated with bedside care. It is imperative that stakeholders in health care organizational systems accept and endorse quality improvement initiatives to meet the needs of the community.

Population and Sampling

The first phase of the capstone project involved reviewing the 3-month post implementation survey (original survey) completed by bedside nurses—those who managed patients in the medical-surgical area of a 715-bed community hospital in southwest Florida. Nurse managers delivered paper copies of a survey entitled "Nurse Self-Evaluation Validated by Nurse Leader Patient Rounding Follow Up" (Appendix A). The original survey results were analyzed. The sample of nurses who completed the original survey was not the same as the sample of nurses who completed the post re-education survey but reflected the same population.

Data Collection

The original survey results were gathered from nurse managers. The survey results were compiled and analyzed to plan the re-education effort. Once re-education was completed, the original survey results were compared to the second survey's findings. A paper copy of the original survey was placed in each nurse's mailbox. An email was sent to all nurses asking them to complete and return the survey within 2

weeks. The same process of distribution was used to obtain responses in the second survey post re-education.

Instrument

The nurses were asked to respond using the survey related to bedside shift report to provide information on barriers to implementation and comments regarding the change in the handoff report process. The intent was to give an accurate indication of whether bedside shift report was occurring and allowing for an open dialogue. Performance questions included the following:

1. Bedside shift report occurred in the room at the bedside.
2. I was facing the patient during bedside shift report.
3. I asked open-ended questions that engaged my patients during bedside shift report.
4. I complete bedside shift report every shift, every day.
5. I asked my patient what is important to them at every bedside shift report.
6. I use SBAR to perform bedside shift report.

The assessment key was as follows: 1—Needs improvement, 2—Performs proficiently, and 3—Role model. The three performance questions were the following: What works best for the staff? What have been your barriers to success? How can we improve BSR?

Protection of Human Subjects

IRB review was requested from both the facility and the Walden IRBs. I had permission from the administration to use the existing surveys and summarize the survey results. The Institutional Review Board determined that this quality improvement project

was exempt. The IRB approved the review of the original survey and distribution of a second survey post re-education from the facility and from Walden University (06-01-15-0316907). Consent was not obtained from participants in the original survey, as it had been administered as part of an evaluation of the new program. The second survey, as part of IRB approval, contained a cover letter (see Appendix C.). Participants were informed that their responses would be kept confidential and would not be identified to their manager. The nurses' responses were kept confidential through the use of anonymous surveys and were protected by de-identified data. Participants did not receive a monetary incentive for the original survey, nor did they receive one for the second survey.

Data Analysis

Data analysis was implemented by summarizing performance questions and written responses to the surveys concerning compliance with the change in practice related to end of shift report at the bedside (see Appendix A.). Analysis of the post re-education survey data was completed in the same manner. The quantitative and qualitative data were placed into an Excel spreadsheet. The survey had quantitative and qualitative sections. The qualitative element of the survey was the space available to write ideas and comments. The survey stated, "Please provide us with your ideas and comments regarding Bedside Shift Report." Raw data were coded, de-identified, and displayed in frequencies.

Project Evaluation Plan

The evaluation plan implemented for this study was designed to determine whether re-educating staff nurses increased the incidence of compliance with evidence-

based practice performance standards for bedside shift report. The evaluation plan provided a better understanding of the process of change. The discipline of program evaluation provided various methods used by program planners to address a wide range of questions regarding a program's performance (Hodges & Videto, 2011). The type of evaluation appropriate for this project was process evaluation.

For the purpose of this project, process evaluation was used to evaluate and improve the effectiveness of the program. The evaluation assessed whether the goals and objectives of the program were met and, if not, why. Data collected through this process may assist program planners in determining the program's effectiveness related to staff compliance and satisfaction with the implementation of bedside shift report. The process evaluation included an assessment of the program's delivery, initial and continued use, nursing satisfaction, and environmental monitoring to ensure staff compliance.

Summary

Section 3 has contained a discussion of the project's design, target population and data collection and analysis. The implementation of bedside shift report is a significant change in practice. The program evaluation process is essential to provide program developers with the information necessary for program success. Process evaluation and visual presentation using the logic model will also be utilized to ensure the program's success.

Section 4: Findings, Discussion, and Implications

Summary of Findings

The purpose of this project was to answer the question of whether re-educating staff nurses on the bedside shift report protocol would increase the acceptance of the change in practice and increase the incidence of compliance. The first objective related to the analysis of the initial 3-month postimplementation survey results. This survey was delivered to staff nurses with instructions to return it to their managers. The results were summarized by the managers and held for analysis. Only one manager returned the original surveys from her unit. In response to Question 1 (The last shift you worked, did bedside shift report occur in the room at the bedside?), 30 of the 30 nurses who completed the survey indicated that they had conducted bedside shift report for the last shift they worked. Table 1 presents a summary of the responses to Question 1.

Table 1

Did Bedside Shift Report Occur?

	Yes, I am a role model	Yes, I performed it proficiently	Yes, but I need improvement
Did bedside shift report occur	10% (n = 3)	67% (n = 20)	23% (n = 7)

Note. N = 30.

Among the 30 survey respondents, qualitative open-ended comments reflected lack of cooperation from the off-going or oncoming nurse. Several stated that they needed help to increase their confidence level with this change. Family interruptions with too many questions, HIIPPA concerns, and patients' basic needs interrupted bedside shift reports. The remaining summarized reports from four other units reflected the same

ideas: “To allow nurses time to take care of the patient, having a care tech available is important,” “HIPPA violations are a threat,” and “Nurses need to be on shift on time.” These barriers guided the re-education to focus on initial postimplementation survey comments. For the re-education survey, I took the original open-ended comments and changed them to a question format to help the nurses quickly complete the survey and to elicit less generic open-ended responses. The re-education plan methodology recommended by Wakefield, Ragan, Brandt, and Tregnago (2012) to use pre-post measures for change in practice related to the transition to bedside shift report was not practical. Gregory, Tan, and Tilrico (2014) argued that, for program success and sustainability, having a conversation with direct care nursing staff is essential before and after implementation of bedside shift report. In addition to the postimplementation survey, and prior to the development and implementation of the re-education program, nurses’ responses to bedside shift report were elicited and added to the survey results. The second objective of analyzing the re-education survey to determine whether performance improved or whether barriers remained was successfully realized, as over 100 comments were elicited.

The re-education survey elicited a total of 89 responses. There were a total of 16 questions: 12 questions with options to select and an opportunity to write in responses, and four open-ended response opportunities. Appendix C presents all open-ended responses.

For Question 1 (The last shift you worked, did bedside shift report occur in the room at the bedside?), 51 of the 68 nurses who completed the survey indicated that they had conducted bedside shift report during the last shift they worked. Table 2 presents a

summary of the responses to the question "The last shift you worked, did bedside shift report occur in the room at the bedside? (Select all that apply)."

Table 2

Did Bedside Shift Report Occur?

Yes, I am a role model	Yes, I performed it proficient-ly	Yes, but I need improve-ment	No, I didn't have cooperation from the off going nurse	No, I didn't have cooperation from the oncoming nurse	No, I need help to increase my confidence level with this change	No, not comfortable	No, forgot	No, family interrupted with too many questions	No, patient basic needs interrupted bedside shift report
23.5% (*n* = 16)	42.6% (*n* = 29)	20.5% (*n* = 14)	10.3% (*n* = 7)	7.3% (*n*=5)	0% (*n*=0)	0% (*n*=0)	3% (*n*=2)	4% (*n*=3)	12% (*n*=8)

N=68

Totals do not equal 100% as question asked to select all that apply.

Of the 68 survey respondents, less than half stated they performed it proficiently. Twenty percent (*n*=14) stated they needed improvement. Of the nurses who attempted to conduct bedside shift report the last shift they worked, 12% (*n*=8) reported interruptions by patient basic needs.

For question 2 -The last time you completed bedside shift report, did you open the EMR to evaluate power plans, medication administration record, and nurse review info? (see Table 2.) 43% (*n*=29) of the 68 respondents indicated they use hand written notes. Thirteen percent (*n*=9) had difficulty locating a computer with a charged battery (see Table 3.).

Table 3. EMR to evaluate PP, MAR and Nurse Review info

	Yes, I am a role model	Yes, I performed it proficiently	Yes, but I need improvement	No, forgot	No, I use my hand written notes	No, difficulty finding computer with a charged battery
The last time you completed bedside shift report, did you open the EMR to evaluate PP, MAR and nurse review info?	12% (*n*=8)	29% (*n*=20)	7% (*n*=5)	1.5% (*n*=1)	43% (*n*=29)	13% (*n*=9)

N=68
Totals do not equal 100% as question asked to select all that apply.

Question 3, 4, 5 and 6 related to conducting a safety check, engaging the patient, asking the patient open ended questions, and asking the patient what is important to them, are directly related to the "bedside process" of bedside shift report (see Table 4.)

Table 4. Safety Checks, Engaging, Open Ended Questions And What Is Important.

	Yes, I am a role model	Yes, I performed it proficiently	Yes, but I need improvement	No, not comfortable	No, forgot	No, family interrupted with too many questions	No, patient sleeping
The last time you completed bedside shift report, did you conduct a brief visual patient safety check?	26% (*n*=18)	68% (*n*=46)	7% (*n*=5)	(*n*=0)	(*n*=0)	1% (*n*=1)	6% (*n*=4)
The last time you completed bedside shift report, did you engage the patient (face the patient)?	26% (*n*=18)	56% (*n*=38)	13% (*n*=9)	(*n*=0)	(*n*=0)	(*n*=0)	10% (*n*=7)
The last shift you worked, did you ask open ended questions that engaged the patient during bedside shift report?	20% (*n*=14)	34% (*n*=23)	15% (*n*=10)	3% (*n*=2)	7% (*n*=5)	9% (*n*=6)	22% (*n*=15)
When I do bedside shift report, I asked my patient what is important to them.	10% (*n*=7)	34% (*n*=23)	32% (*n*=22)	16% (*n*=11)			

N=68
Totals do not equal 100% as question asked to select all that apply.

Question 3, did you conduct a brief visual patient safety check? Was answered, Yes, I performed it proficiently by 68% (*n*=46) of respondents. Question 4, did you engage the patient (face the patient)? Was answered, Yes, I performed it proficiently by 56% (*n*=38) of respondents. Excluding the patients who were sleeping, 44% (*n*=23) responded that they need improvement, were not comfortable or forgot about asking open-ended questions.

These four questions are directly related to the "bedside process" of bedside shift report. Several nurses presented a clear picture of their lack of knowledge about the entire process. For example one nurse answered question 3, did you conduct a brief

visual patient safety check? Yes, I am a role model; answered question 4, did you engage the patient (face the patient)? Yes, I performed it proficiently; and question 5; did you ask open-ended questions that engaged the patient during bedside shift report? No, forgot. Sixteen percent (*n*=11) were not comfortable asking the patient what was important to them.

Question 7 asked, "if they completed bedside shift report every shift, every day". Fifty five answers were given for not completing every shift, 26% (*n*=18) difficulty reporting to or receiving report from several nurses; 12% (*n*=8) stated it takes too long, 10% (*n*=7) stated too many patients were sleeping, 10% (*n*=7) stated ED admissions and/or OR interrupting at shift change, 10% (*n*=7) didn't have cooperation from the off going nurse, and 7% (*n*=5) didn't have cooperation from the on coming nurse. Twenty eight percent (*n*=19) said they performed it proficiently (see Table 5).

Table 5. Complete Bedside Shift Report.

Yes, but I need improvement	Yes, I performed it proficiently	Yes, I am a role model	No, I need help to increase my confidence level with this change	No, it takes me too long	No, I didn't have cooperation from the off going nurse	No, I didn't have cooperation from the oncoming nurse	No, too many patients were sleeping	No, ED admissions and/or OR interrupted at shift change	No, reporting to or receiving report from several nurses
19% (*n* = 13)	28% (*n* = 19)	9% (*n* = 6)	4% (*n* = 3)	12% (*n* = 8)	10% (*n* = 7)	7% (*n* = 5)	10% (*n* = 7)	10% (*n* = 7)	26% (*n* = 18)

Note. *N* = 68. Totals do not equal 100%, as respondents were asked to select all that apply.

In response to Question 8, which asked whether they use SBAR (situation, background, assessment, and recommendation), 12% (*n* = 8) stated that they were role models, and 51% (*n* = 35) stated that they were proficient. The remaining 36% (*n* = 25) were not comfortable with SBAR or preferred a different method. Some comments reflected a misunderstanding of SBAR, such as "Nurses do not like when I used the

SBAR because they say they can look up the info." Throughout the comment sections, statements concerning misunderstanding of SBAR and "sharing information" were common, such as the following:

> I feel it is not my place to give new information to a patient with no plan of action available, it makes the patient worried and upset. It is the MDs role/responsibility to give new information to the patient and provide them with a plan of action.

In response to Question 9, which asked whether respondents had seen the updated bedside shift report rack card, 87% (*n* = 58) indicated that they had not seen it. Only 12% (*n* = 9) had seen the revised bedside shift report rack card; 9% (*n* = 6) thought it was better, and 3% (*n* = 2) said it was about the same.

The cheat sheet, addressed in Question 10, was not seen by the majority of respondents, 59% (*n* = 55). Of those, 40% (*n* = 27) did not think it would help and 19% (*n* = 28) would have liked to see if it helped. Of the 14% (n = 10) who had seen the "cheat sheet," half thought it was helpful, and half said it helped somewhat. No respondent who saw the "cheat sheet" stated that it was not helpful.

Question 11 asked if participants had viewed the facility's bedside shift report video. Among respondents, 66% (*n* = 45) had not seen it when it first came out or when re-education was offered. The 10 nurses (15%) who saw the video said that it was helpful and aided in their understanding of conducting bedside shift report. For Question 12, the respondents were split among not seeing other YouTube videos, recommending viewing additional videos, and not recommending viewing.

Open-ended responses at the end of the survey followed the themes above, such as not wanting to wake the patients, family members disturbing the report process,

patients asking too many questions, and lack of comfort in the process. Additional themes included the length of time to complete bedside shift report and an overall lack of training. The results of the post re-education survey indicated that for managers (i.e., nursing administrators) to effectively implement patient safety initiatives such as bedside shift report, it is important to understand and incorporate the perspectives of frontline staff. Staff members' views on success (i.e., I am a role model) conflicted with their additional answers. On the questions that had "check all that apply," along with "I am a role model," several clicked "I am not comfortable with SBAR" and "I need improvement." Their open-ended responses clarified their clicked responses. In the areas of leadership and education, the frontline staff is focused on different issues that must be considered during program implementation. For example, frontline staff mentioned the importance of further re-education (i.e., "Retrain, people still nitpick and give unnecessary details creating an overly lengthy report"). They also mentioned a consistent message coming from leadership, "Nurse managers/charge nurses must help enforce that this practice is important to this institution and a method to engage the patient and improve outcomes and satisfaction. Staff often does not do it because they don't think it's really required." They also had practical suggestions:

> Bedside reporting works but use common sense. Does the patient want you staring down at them having a conversation about his or her illness? Be very aware of the patients pride, feelings, mood etc. ... Depressed? Annoyed? This is part of it. It looks good on paper but common sense is part of it. Are they tired and want a complete conversation going on at 7am at their bedside? Probably not. A brief, quiet but thorough report while using common sense and courtesy is

key. Just enough to show the patient you're on top of things and to give next nurse a good report. But don't drive the patient crazy. Common sense. Courtesy!

In response to the prompt "if you worked in another facility that has successfully implemented bedside shift report, please use this space below to share your lived experiences," the responses varied from suggestions to support to discouragement: "A facility I worked for used to have pre-made SBAR sheets that were handed out to nurses prior to getting report. This way the nurses had to receive and give report using the same format." "The bedside shift report has also improved staff relationships." Improving the patient experience involves changing the current culture of the way nurses practice and communicate with each other and with their patients." "It is safer but it takes longer and will increase staff overtime."

Discussion of Findings in the Context of the Literature and Framework

This project is supported by Lewin's three-stage change theory along with Kotter's eight-step change model. Lewin's three stages are unfreezing the staff's present position, directing them to a new situation, and refreezing staff in the new process (Hagman et al., 2013). The process of freezing in this case included confronting and challenging current staff members regarding their attitudes and beliefs related to bedside shift reporting. The change process involved educating the staff regarding the process of bedside shift report introduction and implementation. Refreezing was achieved when staff incorporated the bedside shift report into daily practice (Vines, Dupler, Van Son, & Guido, 2014). The project was also supported by Paplua's interpersonal relations theory. Paplua's theory suggests a therapeutic relationship that fosters trust and mutual

understanding as well as communication and mutual goal setting between nurses and patients (Radtke, 2013).

Kotter's eight-step change theory was used as a predictor of the success of the program, in that the largest obstacles that occurred related to improving staff's performance of bedside shift report. These barriers were failure to articulate the change related to rationale, time frame, and steps involved in the change process. The stages included creating a sense of urgency, forming an alliance, creating a vision, removing obstacles, acknowledging successes, building on change, and cementing the change in the culture of the unit (Zaccagnini & White, 2011). The theories of Lewin and Kotter assisted in the model for change related to the implementation of bedside shift report.

Implications

Implications for Practice

The survey asked bedside nurses to respond to performance questions and to provide information on their barriers and comments regarding Bedside Shift Report. The assessment of the transition to bedside nurse shift handoffs is essential (Gregory et al., 2014; McMurray et al., 2010; Olson-Sitki et al., 2013). Bedside shift report is imperative in today's health environment as a communication tool derived from evidenced-based practice to provide patient-centered care. This type of handoff helps to engage patients in their care, leading to improved safety and quality of care. It is essential to have the best communication possible during a transition in care to provide a safe and efficient handoff. Engaging the patient and family in nurse bedside shift report gives them the opportunity to hear what has occurred throughout the shift and the next steps in their care. It also gives them the chance to ask questions and provide input into the care process.

The ultimate goal is to prevent medical errors and adverse events that can be costly for the facility as well as the involved staff. Training tools included a video and handouts.

Bedside shift-to-shift report is not a new concept to nursing and is acknowledged in the literature as an effective means for patient engagement (Grant & Colello, 2010). Implications of this project include stakeholders paying attention to the results of this study. It is imperative that nurses provide adequate communication to their patients and staff members for the safety of all involved in the care of the patient. The computer based training on bedside shift report may have to be reviewed yearly to remind staff of the importance of this protocol as well as the understanding that it is a requirement in this organization. Increasing the nurses evidence-based practice knowledge will have a positive impact on the staff members with the result of the safer patient care at this organization.

For the bedside shift report program to be successful, the original bedside shift report committee could be dissolved, and the medical-surgical shared decision-making committee can take over. With this valuable feedback, they can develop a continuing education program that focuses not just on learning from mistakes, but on recognizing the "role models". Ensuring the nurses review the bedside monitoring protocol during their yearly competencies could reinforce the protocol used to perform bedside shift report for the safety of the patients and the staff in this facility.

Many studies address the role of champions (McMurray et al., 2010; Olson-Stiki Weitzel, & Gilsson, 2013; Wakefield, Ragan, Brandt, & Tregnago, 2012). The alignment of both frontline staff and nursing administration with their goal for program success is

essential, but only staff mentioned the importance of the approachability and social/interpersonal skills of the champions.

Implications for Future Research

This project is just one of many that can be derived from this DNP capstone while maintaining the goal of safety and improved communication between patients and staff members. A longitudinal study can be performed to see if this re-education has remained in the nurse's performance when providing a report to the oncoming shift at six months and again at a year. Further studies can include:

- An analysis of which unit having highest non-compliance rate
- An analysis of the type of non-compliance is most frequent in comparison to each unit
- An analysis of the tenure of nurses who are found to be non-compliant

Impact on Social Change

Social change involves a modification in behavior, cultural values and norms as well as the structure and function of society. This change occurs in nursing particularly in roles with the result of a modification in attitudes, beliefs and expectations. The nursing profession reflects new knowledge and is frequently being increased and transferred to hands-on practice. A goal of mine is to function as a scholar-practitioner to assist in positive social changes in my profession. Improving human and social conditions by creating and applying ideas in the nursing profession using research, policy and societal considerations that will make a difference in patient's lives and their communities. The results of this project may impact patients in a positive manner by

providing a better quality of care in this facility. Participating and engaging politically with stakeholders is essential for social change.

Project Strengths and Limitations

Strengths

My familiarity with the survey and re-education process is strength in this project as it allowed me to assess and interpret the results. Strengths of the project also include the fact that bedside shift report initiated in this facility in May 2014. The nursing staff was familiar with the expected behavior in performing this communication. Bedside shift report is known to be an effective communication tool in preventing errors and providing safe and efficient care to patients. Nurse bedside shift report helps ensure the safe handoff of care between nurses by involving the patient and family (U.S. Department of Health and Human Services' [HHS], n.d.). I have also been a direct care nurse responsible for carrying out bedside shift report with my colleagues, patients, and their families. I received support from my fellow bedside nurses regarding their honest input regarding the re-education survey. The population of the project included all registered nurses in this acute care facility located in southwestern Florida. The survey implemented post re-education was anonymous preventing bias.

Limitations

Limitations included the fact that not every nurse participated in the survey due to the completion being elective. The original survey was never analyzed, and the nurse managers held the results, which was not shared with others either in administration or management. Another limitation of this project includes self-reporting related to nurse's

compliance of consistently performing bedside shift report. A concern associated with self-reporting of compliance with the change to bedside shift report is the fact that non-compliance results in disciplinary action at this time in the implementation process.

Managers did not participate nor was present at the beginning or end of every shift. As a result, the managers had no idea if the protocol was being implemented in their unit, making it impossible to investigate their input on implementation of this project. The project focus was re-education of bedside shift report for the direct care nursing staff. After post re-education results reviewed, education should have been designed to target the re-design of the implemented bedside shift report process based on nurses post re-education comments.

Recommendations for Remediation of Limitations

According to White & Dudley-Brown (2012) acknowledging a connection between the nurses' work environment and their quality of care, leaders can use Microsystems as a base to improve the process of quality and performances. The nurse manager could assess their unit's participation in bedside shift report to ensure compliance and safety of the patients through proper communication on their unit.

Analysis of Self

My license to practice nursing became active in 1982, and I have continually maintained the highest standard of care, judgment, knowledge, attitude and skills required to care for my patients. The knowledge and skills required continuing to provide safe, quality care, is credited to the advancement of my education through the years. My future as a researcher and nurse leader have been enhanced by strategies learned to

translate research into evidence-based practice and bring it to the bedside. Newfound knowledge of health care policy has enhanced my ability to implement evidence-based practices at the bedside. The education obtained through Walden has provided me an opportunity to accept a position as a nurse researcher. According to the DNP essentials, this educational foundation will enable graduates to develop, implement and evaluate clinical outcomes and the health of the population (AACN, 2006). My persistent efforts are performing research utilizing best practices to further the nursing profession by improving patient health outcomes will continue to evolve long after my conferral date. A lifelong commitment of contributions is needed in the field of nursing to improve results and will be accomplished by being an active participant in professional organizations. According to the mission of the American Nurses Association (ANA, 2010), advancement in the quality and delivery of healthcare can be achieved through policy advocacy, legislation, and regulation. The nursing profession is changing on a daily basis, and it is imperative that stakeholders in health care organizational systems acknowledge and endorse quality improvement initiatives for the needs of the community they serve.

Scholarly Reflection

The American Association of Colleges of Nursing (AACN) recommended by 2015 the DNP would be a terminal practice degree for advanced practice nurses. In 2004, a position statement was released on the Practice Doctorate in nursing proclaiming this endorsement. The purpose of this degree is to meet the changing, and growing healthcare system demands by providing nurses with the education and knowledge to be expert clinicians (AACN, 2006).

The DNP degree is built upon the current master's degree content and differs from the focus of research in the Ph.D. degree by preparing clinicians to incorporate research in advance nursing practice (AACN, 2006). The program consists of core courses and clinical fieldwork experiences to provide precise, current and advanced care to the patients. I have learned leadership roles in organizations, applied research to evidenced-based practice at the bedside, recognized quality improvement initiatives, new technology and how to advance nursing through health policy.

My quality improvement initiative for bedside shift report allows me to put into practice the skills learned from the DNP program. The utilization of change theories such as, Lewin's three-stage change theory and Kotter's eight-step change model is one example that guided the capstone project. The facility where the quality improvement project conducted has adopted this practice of bedside shift report; however, the staff is not complying with the new practice. The three-stage theory would be beneficial by unfreezing the present habits of the direct care nurse, re-educating on the new practices and refreezing staff's ideas and practices in the required practice of bedside shift report.

Kotter's eight-step change model could assist in the successful implementation of bedside shift report. Kotter's model creates a sense of urgency, forms a coalition, creates a vision and communicates this vision, assess and remove any obstacles. The change model assists with improving the old practice of report given without patient engagement, to the new practice of bedside report.

The application of these theories applied to a practice problem. The results improved outcomes for the population that translated research findings into practice (Walden University, School of Nursing 2012) and met the School of Nursing's outcomes.

My clinical experiences allowed me to learn and grow from the observation of political and administrative practices and the impact it had on the implementation of my project. I have increased my knowledge of quality improvement projects through the observation and participation in many projects throughout my fieldwork experiences.

Practitioner Reflection

Utilizing the DNP essentials from the American Association of College Essentials for Doctoral Education (2006) was a useful guide throughout my educational process of my DNP. Entering the final stages of my DNP degree there is a high level of self-confidence on my part in my clinical skills as a registered nurse and beginning in a new specialty of nursing research. Upon starting my new position in research my excitement and willingness to learn as well as my education will serve me well in managing and contributing to future research projects. The combination of my years of experience, knowledge, and leadership skills allows me the title of an advanced practice nurse.

Project Developer Reflection

I have incorporated many practices from completing Walden's DNP program. Planning organizing and utilizing resources are just a few examples utilized in developing and completing my project. Classifying what needs to be completed and tasks associated with the identified projects provided me with an understanding of the necessary relationships. Formulating evidence-based practice solutions developed from my learning by completing the DNP program will improve patient care and provide beneficial changes utilized in all my future projects.

Future Professional Development

My intention is to continue research in best practices and evidence-based practices to improve the nursing profession. From many years of experience at the bedside, my passion for providing the best clinical care will always be embedded in me. The participation and initiation of research studies will assist with moving the profession forward and improving healthcare. This development may be accomplished from organizations such as the National Institute of Nursing Research that are involved in nursing research.

Summary and Conclusions

The re-education revealed nurses can have a commitment to perform daily bedside shift report if specific conditions are supported, such as, understanding of the process improves comfort level and misconceptions are addressed. Social change of this magnitude, for this one acute care hospital, indicates the voice of the bedside nurse must be heard. The nurses are supportive of the goal of bedside shift report. To make this goal a reality to promote patient safety, improved patient outcomes, and increase HCAHPS related to nurse-patient communication, work from Lewin and Kotter may assist if used at the birth of this organizational change. With the findings from the survey of the re-education plan, a detailed plan will be presented to the Shared Decision Making Medical-Surgical Council. The program includes dissemination of bedside shift report tools (patient education rack card, cheat sheet, and video) as well as encouraging the use of additional videos.

The education received from Walden University's DNP program has already provided me the opportunity to start a new position as a researcher in a facility where I am currently employed. My feelings of increased professional growth in the nursing profession are evident with this change in my career and perceived as a necessary step upon entering the research field. The most satisfying part of this program is the realization that my impact as a leader and agent for change achieved through research projects in the nursing field for the purpose of improving patient outcomes.

Section 5: Scholarly Product and Dissemination

Dissemination of project results is an important and integral aspect of the DNP capstone. The doctorate of nursing practice (DNP) degree has provided me the opportunity to implement and evaluate evidence-based practice (EBP) project related to the re-education, implementation and re-evaluation of bedside shift report. It is essential for the DNP prepared professional to dissemination the findings to stakeholders and other healthcare professionals. This dissemination provides a means to share the results of the project so innovations for practice can be replicated or applied in other settings (Forsyth, Wright, Scherb, & Gaspar, 2010). Dissemination permits the project designer an opportunity to share successes as well as areas for growth and development. Zaccagnini and White (2011, p. 485) identified two purposes for the dissemination of DNP project results: reporting the results to stakeholders and the academic community, and dissemination to professionals in similar environments.

The DNP capstone project will be disseminated internally and externally. Internal dissemination of the project will be accomplished through a presentation to the nursing executive council (NEC). The council is comprised of Chief Nursing Officer (CNO), three Associate Chief Nursing Officers (ACNOs), a director of education, and the director of research evidence-based practice and innovations. The NEC will determine which of the Shared Decision Making Councils will be best served by reviewing the survey findings. The venue for dissemination will be a PowerPoint presentation (see Appendix D). I will be collaborating with the designated Shared Decision Making Council to develop educational sessions at nursing staff meetings and unit huddles.

External dissemination will be accomplished by presenting the results of the DNP capstone at the Fall 2016 Francine Gomberg Research and Evidence-Based Practice Conference in Ft. Myers, Florida. An additional venue for external dissemination will be through a written dissemination; the journal targeted for dissemination is Jacobs Journal of Nursing and Care. The manuscript will not detail the full project, but rather consist of a short communication creating awareness about the development of bedside shift report process and changing the culture. Dissemination is the final process in the DNP Capstone project. The dissemination of results in all project endeavors is critical to the process of quality improvements. Without dissemination, the efforts of quality improvement projects would benefit just a few, dissemination of findings will benefit many.

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Appendix A: Bedside Shift Report (BSR) Competency Survey

Competency: Nurse Self-Evaluation validated by Nurse Leader Patient Rounding Follow Up.

Instructions:

Nurses: Complete and return SELF ASSESSMENT to your Nurse Manger by **07/27/2014**.

Nurse Managers: Complete 3 Patient Rounding Follow-ups to confirm competency. Please send your unit summary/evaluation of competency compliance by email to BSR Committee via xxxxxxx by **08/05/2014**.

Bedside Shift Report Performance Questions	**Self Assessment** (Nurse Completes)	Performed by Leader		
	Assessment Key: 1- Needs Improvement 2- Performs Proficiently 3- Role Model	Patient Follow up Round 1	Patient Follow up Round 2	Patient Follow up Round 2
1. Bedside Shift Report occurred in the room at the bedside.				
2. I was facing the patient during Bedside Shift Report.				
3. I asked open ended questions that engaged my patients during Bedside Shift Report.				
4. I complete Bedside Shift Report every shift, every day.				
5. I asked my patient what is important to them at every bedside shift report.				
6. I use SBAR to perform Bedside Shift Report.				

Please use the back of this evaluation to provide us with your ideas and comments regarding Bedside Shift Report. We would like to know what works best for the staff, what your barriers are to success have been, and what we can do to improve BSR.

Critical Elements of BSR:

1. Use AIDET to introduce staff
2. Invite the patient to join in
3. Open the EMR to evaluate PP, MAR and Nurse Review info
4. Conduct a verbal SBAR report with the patient. Use words that the patient and family can understand.

   S = **Situation**. Why is the patient here? (Diagnosis, MD and Consults, Isolation Status)

   B = **Background**. Give past medical history *pertinent* to current admission

   A = **Assessment**. Patient Safety Check and Pain/Tele/Sock status

   R = **Recommendation**. What matters to the patient this shift?

5. Conduct a *brief visual* Patient Safety Check
6. Review Tasks
7. Identify what matters to the patient for today

Please provide us with your ideas and comments regarding Bedside Shift Report.

1. What works best for the staff?

   _____

   _____

2. What have been your barriers to success?

   _____

   _____

3. How can we improve BSR?

   _____

   _____

Appendix B: Cover Letter to Bedside Shift Report (BSR) Re-Implementation Survey

You have been selected to complete this NCH Healthcare System Bedside Shift Report (BSR) Re-Implementation Survey because your input is important to the success of BSR. The post re-implementation survey will be analyzed by Jessica Palumbo, MSN, RN, as part of her DNP capstone project.

The purpose of this study is to answer the question if re-educating staff nurses on the bedside shift report protocol will increase the acceptance of the change in practice for the staff nurse and will increase the incidence of compliance based on the post re-education survey.

Please complete and return this SELF ASSESSMENT to your Nurse Manager by July 1, 2015. Your participation is voluntary; there is no penalty, foreseeable risks or discomforts in completing the survey, as your results will remain anonymous.

The anticipated benefits for participation and the premise for the implementation of bedside shift report proposes that moving hand off shift report to the bedside will improve patient satisfaction scores by improving: 1) patient safety and quality, 2) patient experience of care, 3) nursing staff satisfaction, and 4) time management and accountability between nurses (Agency for Healthcare Research and Quality [AHRQ], 2013). If our patient satisfaction score improve we may receive a bonus.

If you have any questions about the survey please contact Jessica 239-687-9265.

If you have questions about your rights as participants contact Marisa Wilson at Walden University Marisa.wilson@waldenu.edu

Please keep this page as your informed consent.

Appendix C: Open-Ended Responses From All Questions

Question 1: The last shift you worked, did Bedside Shift Report occur in the room at the bedside?

If other reason for not completing Bedside Shift Report please specify

- IT is very difficult when you have four different nurses to give report to and try and get out on time.
- In the morning, breakfast comes at 7am, some Brookdale patients have 7am and 8am therapy sessions, and the CT's are in the rooms getting them dressed. We have 2 patients per room, and there is barely enough room for two staff members in addition to the two patients, two walkers, two wheelchairs, etc. Nurses have 7 patients at night and 6 during the day. There is not enough time or space to do a full bedside shift report.
- Not appropriate to do it at bedside with some patients. Some were up all night and required to let them sleep. Some were just medicated for pain.
- Used to old ways of sitting while getting report
- No One enforces it
- Certain things need to be discussed away from patient as part of report often. It may be information you don't want patient to hear or it may be inappropriate to continually speak about the patients diagnosis in front of him/her. It may make the patient feel worse, powerless, bad whatever. I do agree with bedside, but it often is half bedside, half away from patient for these reasons. It may be inappropriate to let a neighboring patient hear every detail regarding his or her diagnosis also. Especially if visitors are around.
- Charge nurse no patients
- PT ASKED RNS TO BE QUITE AND LET HIM SLEEP
- pt was sleeping.
- Pt does not want to be woken up at 0645 in am for report
- Where I work there are too many visitors in the room at1845. At 0600 the patient may have just fell back to sleep after being up all night with newborn

Question 2: The last time you completed Bedside Shift Report, did you open the EMR to evaluate PP, MAR and Nurse Review info?

If other reason for not opening the EMR please specify

- No, I looked at this prior to bedside report
- I didn’t know we were supposed to do this It makes it more time consuming Things on paper that look good don’t always work in the real world

- RNs are in a huge rush in the morning to get patient assessments and medications (pain meds are huge before therapy) done before patients go off to therapy scheduled at 7am, 8am and 9am. Evaluating PP's is done once the first med passes are completed and charting can begin.
- No if that was done for every patient REPORT HANDOFF Would be going on for 30 plus min
- Not enough room in semiprivate room, worsening by patient's family visiting.
- Sometimes it was already done or printed out
- I will review the EMR prior to shift change.
- Too lengthy
- We often have the details already on our hand sheets. Dragging a computer into a tight room may add to an unwanted commotion and may be very time consuming. Often patients want to have the least amounts of commotion. Not always ideal for the patients needs. Quiet, rest etc.
- Usually I use hand written notes due to the off-going nurses still using the computers, especially during season.
- Difficulty to find computer because of lots of isolation rooms
- I have noticed nurses that don't write down a report on their patients forget important info & constantly have to log on to computer to find out that information whether a physician or family member is asking questions.

Question 3: The last time you completed Bedside Shift Report; did you conduct a brief visual Patient Safety Check?

Other (please specify)

- No. Our rounding is for safety. Assessing what is important to my patients occurs when I am doing their initial assessment/medications before therapy and throughout the day. This is not necessary during bedside shift report.
- no not to every patient
- yes after we introduce the oncoming nurse
- Not enough time when receiving report on 6 pts, and often from multiple nurses to ask what is important during the 30-minute shift report window. I ask it when I return to the room for the first time after shift change.
- I ask the patient if they have any questions about what the nurse and I have spoken about
- They do not want bedside report if they been there a couple of days

If other reason for not conducting safety check please specify

- trust out going nurse
- This is where bedside reports are so important. Without them, the patient may go unseen for over an hour at shift changes.
- Pt are a sleep at 0645 in am

Question 4: The last time you completed Bedside Shift Report, did you engage the patient (face the patient)?

If other reason for not engaging the patient please specify

- This is important
- No several family members/friends were visiting and the patients didn't want to be disturbed -two patients were resting and one was off the floor -shift report is easier to do at 1900 rather than 0630...
- pt is sleeping or sedated
- Bedside Shift report is not consistently performed and therefore patients can get nervous or confused when the nurses are coming into the room to discuss the plan. BSR is often times more difficult to perform at 0700 when patient is just waking up.
- yes but patient kept interrupting
- its important to introduce the next nurse to the patient. Occasionally you do get grumpy patients that really hate being bothered but still important. In those cases you keep it short and least amount of commotion.
- Pt are asleep at 0645

Question 5: The last shift you worked, did you ask open ended questions that engaged the patient during Bedside Shift Report?

If other reason for not asking open ended questions that engaged the patient please specify

- Not enough time to do this during rounding at Brookdale
- No I do that during my assessment. If we talked to every patient, opened the EMR and got report we would never have time to take care of the patient, especially if you are getting report from more then one RN.
- Sometimes patient do not want to participate in bedside shift report in the mornings because they are tired.
- NO, UNFORTUNATELY. USUALLY TOO RUSHED FOR MORE THAN BEDSIDE REPORT & BASIC INTRO.

Question 6: When I do bedside shift report, I asked my patient what is important to them.

No comments

Question 7: I complete Bedside Shift Report every shift, every day.

Other (please specify)

- every shift change is different we are always getting pts at shift report
- Numerous new admissions at change of shift

- Too much very personal info (STDs, abortions, etc) in front of family members. Most of report is given away from pt, but visualization then includes patient
- If you have to get or give report to more than 2 nurses it will take longer.
- We try to do bedside rounds, but with several nurses to give report to, or patients coming and or going it is not always down.
- Our unit is currently working on pushing bedside shift report and enforcing that everyone participates daily.
- The biggest problem (always) is getting everyone to cooperate. I think monitoring compliance is key. Accountability.
- Morning shift change the patients are almost always sleeping and do not want to be disturbed, and evening shift change is often interrupted by the ER hurrying to call report on patients. It also takes a long time to do when you give report to multiple nurses. When night shift leaves in the mornings we are sometimes giving report to three nurses. Often when I ask the other nurse about going room to room they say they don't want to.
- Receive report. From 3 plus nurse
- When you have 8-10 patients that you need to give report on & maybe 2-3 nurses this is too time consuming; would always be clocking out late.

Question 8: When I do bedside shift report, I use SBAR (situation, background, assessment, and recommendation).

Other (please specify)

- Is hard when patients have more than one situation to be addresses.
- Sometimes-but I go through my checklist
- I typically tell the oncoming nurse what is pertinent to the patient's care including the plan for the day and plan for discharge. Certain information that has not been provided to the patient by the MD I do not always feel comfortable sharing with the patient i.e. new diagnosis or concerning test findings I feel it is not my place to give new information to a patient with no plan of action available, it makes the patient worried and upset. It is the MDs role/responsibility to give new information to the patient and provide them with a plan of action
- Nurse do not like when I used the sbar because they say they can look up the info

Question 9: Two weeks ago the Bedside Shift Report rack card was updated. Have you seen it? It has two women with clipboards, in place of the three women. If yes what do you think? (Click all that apply.)

No comments

Question 10: Two weeks ago "cheat sheets" for Bedside Shift Report were passed out and left at each nurses station (except Critical Care). Have you seen the cheat sheet? If yes what do you think?

Here are my suggestions about "cheat sheets".
None

Question 11: Two weeks ago all nurses were emailed a link to NCH Bedside Shift Report video. Do you feel this video aided in your understanding of conducting bedside shift report? If yes what do you think? Would it be helpful to watch other YouTube videos? (Click all that apply.)

Here are my suggestions.

- No, as it can be down if all factors happen in your favor, sometimes its just not possible. It is a great tool.
- Bedside reporting works but use common sense. Does the patient want you staring down at the having a conversation about his or her illness? Be very aware of the patients pride, feelings, mood etc.... Depressed? Annoyed? This is part of it. It looks good on paper but common sense is part of it. Are they tired and want a complete conversation going on at 7am at their bedside? Probably not. A brief, quiet but thorough report while using common sense and courtesy is key. Just enough to show the patient your on top of things and to give next nurse a good report. But don't drive the patient crazy. Common sense. Courtesy!
- I've seen the other y tube videos

If you worked in another facility that has successfully implemented Bedside Shift Report , please use this space below to share your lived experiences.

Open-Ended Response

- Worked very well. Caught errors
- N/A
- have not
- It is not always practical
- It is safer but it takes longer and will increase staff overtime.
- IT PROVIDES MORE ORGANIZED DETAIL FLOW OF INFORMATION ACROSS THE SYSTEM
- Manager held nurses accountable for performing bedside report and this was included in evaluations.
- it worked, but you are not always so rushed -clocking out and completing your last minute tasks -also sending patients at change of shift affects bedside report, the manager or charge nurse monitored the nurses at change of shift

- A facility I worked for used to have pre-made SBAR sheets that were handed out to nurses prior to getting report. This way the nurses had to receive and give report using the same format.
- It works, but always be aware of the patients wants and needs. Always.
- Other facilities don't need to use BSR because the doctors and nurses round together and the patient doesn't need to be bothered
- Other facilities do not do bedside reporting other then the ed
- The bedside shift report has also improved staff relationships. Improving the patient experience involves changing the current culture of the way nurses practice and communicate with each other and with their patients.

If not mentioned above, what have been your barriers to conducting a successful Bedside Shift Report?

Open-Ended Response

- too many patients sleeping, nurses who did not like doing the bedside report
- i feel it's inappropriate
- Sometimes the nurse who is giving/taking report refused to go to the patient's room.
- when you started bedside shift report you did it when we were being held accountable for overtime shift report takes much longer in reality it is a good thing but needs to be reintroduced . Threatening nurses with points is not a productive way to do things. Also having people spy on others isn't going to make the program better. I think this was mandated from upper management . were any bedside nurses asked as a whole how they felt about doing this? Why was it started at the height of season when everyone is busy and stressed and not open to new suggestions THE SUCCESS OF PROGRAMS IS ALL ABOUT TIMING MANAGEMENT NEEDS TO THINK ABOUT THIS
- Brookdale is so unique in that our patients have breakfast at 7am, some have therapy as early as 7am, but most others have therapy at 8am and 9am and require getting fully clothed with shirts, underwear, pants, socks, sneakers, orthotic devices, etc and when RNs have 7 pts at night and 6 during the day, there is simply not enough time to do a bedside shirt report.
- Families
- It was mentioned above. If patient's are not sleeping while doing bedside shift report, there are a lot of interruptions and with giving report to multiple nurses, I get out late every time if we go into every one of my patient's room.
- willingness of all involved to participate
- TIME !!!!!!!!!!!!
- Patient wants to know more information that is not available or that requires more intervention from off going shift nurse and as above will increase the overtime.

- NON-STANDARDIZED FORMAT OF HANDING OFF REPORT, PROVIDE LIMITED IMFORMATION
- The oncoming nurse doesn't want to do bedside shift report.
- By in from staff.
- Too many pts to perform all steps of bedside shift report.
- pt sleeping, not enough time, family members asking too many questions, patients asking for assistance and not understanding that we are doing bedside shift report
- time during report
- family interrupting
- Your skill level and realizes how much it impacts not only patient care, it also impacts patient satisfaction and quality outcomes.
- time
- off coming night shift staff who do not want to "wake the patient." Which is not a strong reason given I will wake the patient at 0715 for vital signs and assessment.
- Lack of training and the time allotted to incorporate the new method of shift-to-shift report
- Depending on the nurse giving report sometimes I feel we are taking too long to conduct bedside shift report. I understand we should be visually assessing and making sure everything with the patient is okay (lines ext) However I do not feel it is appropriate to be checking on everything, the oncoming nurse has 12 hours to do her own head to toe assessment. I also feel like it should be discussed our place in telling the patient new information, it is very concerning for the patient to hear brand new information about their status/care when the doctor has not mentioned it to them before. This tends to cause unnecessary stress and worry for our patients. I want my patient to know everything about their care and be fully informed but as the RN I do not feel we should be giving concerning lab/test finding information to the patient before the doctor has seen them.
- People late and rushing or just not cooperating. They think it is ridiculous and unnecessary
- Barriers to a successful bedside shift report are definitely the lack of time and cooperation from others. Nurses seem to think that if you walk into a patient's room, you'll be in there longer than expected (which happens often).
- WILLING TO TRY
- Giving reports to Nurses that are noncompliant.
- Time is a big factor. It takes too long to give sometimes up to three nurses bed side report, especially in the evenings when family members interrupting. It is not conducive to getting the off-going shift out the door on time and the on-coming shift started in a timely fashion.
- patients can commonly have many interruptions, such as wanting to give a history on what is being briefly reported.

If not mentioned above, what works best for conducting Bedside Shift Report?

Open-Ended Response

- sometimes it is very hard to do with a difficult pt load and multiple nurses to report to and to get out on time
- If therapy sessions started at 9am at the earliest, bedside shift report would be feasible for Brookdale RN's, but not the way it is currently set up.
- Teamwork
- Will make commitment to perform to the best of my ability
- Brief interaction with the patient.
- Given report in a quiet private area and then go around.
- SYSTEMATIC STANDAEDIZED FORMAT
- Smaller pt loads that allow us to open the computer and interact with the pt during shift report.
- Having a computer available for PP, MAR etc would be beneficial to add to my practice and I wouldn't have to come in early to look up that patient. It would expedite shift change.
- I feel like the intended purpose of bedside shift report is to involve the patient in such a way that they feel informed about their care. That they know the plan for the day/plan for discharge. I think this should be the main purpose of what is stated at the bedside. Additional info that perhaps the doctors have no spoken to the patient about yet can be discussed outside of the room so as not to upset/worry family and the patient i.e. new lab results, test results
- People being on time and knowing this is what needs to be done no matter what
- COMPUTER
- No bedside reporting in the am

Other than what you have already commented on, how can we improve your ability to conduct a successful Bedside Shift Report?

Open-Ended Response

- I am not an advocate of BSR, bedside pt intro and safety review are more appropriate
- The program has become such a negative subject with nurses now make it something you want to do instead of have to do or be punished. It needs to be reintroduced as something positive instead of another task piled on to make our assignment more difficult. As I said before success of a program is tied to the timing it introduced. The timing was all wrong for this project and it has a negative vibration. It has to be introduced as something nurses want to do instead of something they have to do or will be punished The timing and the presentation of this program doomed it from the start. It is universally perceived as a negative throughout the hospital at both campuses. Nurses exchange viewpoints and this is a thorn in everyone’s side. Start small time it well when

there is time to do it, when nurses aren't stressed to the maximum and there is not a punitive action associated with it

- Take into consideration every unit is unique and requirements for bedside shift report should be altered to accommodate what is best for patients and RNs on each unit.
- will review tools provided and work to achieve goal
- Both off going and incoming shifts have to be aware that nursing is 24 hrs and that sometimes things have to be left to be followed up by whoever applies.
- SYSTEMATIC STANDAEDIZED FORMAT
- I think it would help if we weren't so rushed and if the clinical techs could help with patient needs during shift change and also if report isn't called /or or patients being transferred at change of shift.
- educate staff on how to perform a more effective bedside shift report where we can still clock out on time
- n/a
- RN should come on time and should be assigned to same pts. for continuity of care.
- Have managers or charge nurses round at change of shift.
- Nurse managers/charge nurses must help enforce that this practice is important to this institution and a method to engage the patient and improve outcomes and satisfaction. Staff often don't do it because they don't think its really required.
- Retrain, people still nitpick and give unnecessary details creating an overly lengthy report.
- Not doing it, because most of the time md has not told the pt about positive lab or radiology reports.
- See above. Bedside report sounds good on paper but it is very unrealistic.

Appendix D: PowerPoint Presentation

Implementing Bedside Shift Report: An Evaluation of Change in Practice

Jessica Palumbo MSN, RN
DNP Student

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Background

- Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) survey results from 2013 revealed a need for improvement in nurse-patient communication at the unit level.
- Bedside shift report implemented.
- Three month postimplementation survey distributed

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Bedside Shift Report Process

- Patient assignment paper
- Nurse-nurse communication
- Blended method ?
- Computers an wheels
- Report given
- Patient engagement

Purpose of the Project

The purpose of this project was to determine whether re-educating staff nurses on the bedside shift report protocol would increase the acceptance of the change in practice for staff nurses and increase the incidence of compliance based on the post re-education survey.

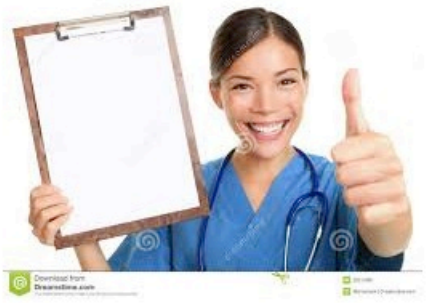
Research question

Will assisting the organization in evaluating the current bedside shift report process, in re-educating staff, and in reimplementing bedside shift report change what nurses think about the process?

Defining Terms:

- ***Bedside Nurse***
- ***Bedside Shift Report***
- ***Change–of-Shift***
- ***Communication***

Defining Terms



- *HCAHPS Scores*
- *Patient-Centered Care*
- *Patient Engagement*
- *Situation-background-assessment-recommendation*
- *Standardization*

Review of Literature:

- Providing the shift change report at the bedside is a skill that requires training, practice, evaluation and feedback from management (Welsh, Flanagan & Ebright, 2010).
- Clark and Persuad (2012) address resistance to change may be reduced by answering questions and providing feedback throughout the change process to ensure success.

Review of Literature:

- Wakefield, Ragan, Brandt and Tregnago (2012) consider optimization of the process after implementation to include the need to assess the nursing staffs attitudes' prior to and after the change.

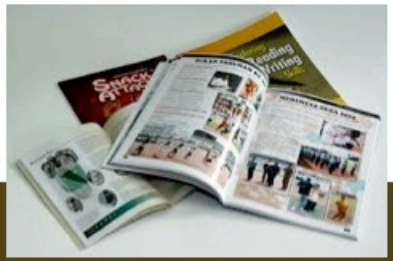
- Staggers & Jennings (2009) qualitative study found efficiencies in report can be gained from EMR; themes emerged that can be used to improve a bedside report protocol.

- Nelson and Massey(2010) discuss change of shift EMR templates can enhance and sustain improvement in bedside shift report.

Review of Literature:

- Bedside shift-to-shift report is not a new concept to nursing and is acknowledged in the literature as an effective means for patient engagement (Grant & Colello, 2010).

- Laws and Amato (2010) propose staff education is necessary to elicit buy-in from staff nurses



Project Design/Methods

The first phase is to review the three-month post implementation survey (original survey).

A second phase is reviewing the survey obtained after re-education.

Data Collection & Analysis

- **Analysis the pre and post survey data.**
- **The mixed method, of quantitative and qualitative.**

Presentation of Findings

- Findings related to the literature confirmed that assessment of the transition to bedside nurse shift handoffs is essential (Gregory et al., 2014; McMurray et al., 2010; Olson-Sitki et al., 2013).

- 68 respondents provided 100 responses.

Survey Question:

Question 1: The last shift you worked, did Bedside Shift Report occur in the room at the bedside?

- 51 of the 68 nurses, who completed the survey, conducted Bedside Shift Report the last shift they worked.

Question 2: The last time you completed Bedside Shift Report, did you open the EMR to evaluate Power Plans, Medication Administration Record, and Nurse Review info?

- 43% (*n*=29) of the 68 respondents indicated they use hand written notes

Question 3 - 6

	Yes*	No, not comfortable	No, forgot	No, family interrupted with too many questions	No, patient sleeping
3. The last time you completed bedside shift report, did you conduct a brief visual patient safety check?	101% (*n*=69)	(*n*=0)	(*n*=0)	1% (*n*=1)	6% (*n*=4)
4. The last time you completed bedside shift report, did you engage the patient (face the patient)?	93% (*n*=158)	(*n*=0)	(*n*=0)	(*n*=0)	10% (*n*=7)
5. The last shift you worked, did you ask open ended questions that engaged the patient during bedside shift report?	69% (*n*=47)	3% (*n*=2)	7% (*n*=5)	9% (*n*=6)	22% (*n*=15)
6. When I do bedside shift report, I asked my patient what is important to them.	76% (*n*=52)	16% (*n*=11)	(*n*=0)	(*n*=0)	(*n*=0)

*Yes, I am a role model
Yes, I performed it proficiently
Yes, but I need improvement

N=68
Totals do not equal 100% as question asked to select all that apply.

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Question 7: Do you complete bedside shift report every shift, every day?

Yes	No, reporting to or receiving report from several nurses	No, it takes me too long	No, too many patients were sleeping	No, ED admissions and/or OR interrupted at shift change	No, I didn't have cooperation from the off going nurse	No, I didn't have cooperation from the oncoming nurse	No, I need help to increase my confidence level with this change
108% (n = 38)	26% (n = 18)	12% (n = 8)	10% (n = 7)	10% (n = 7)	10% (n = 7)	7% (n = 5)	4% (n = 3)

Note. N = 68. Totals do not equal 100%, as respondents were asked to select all that apply.

Question 8: When asked if they use SBAR (situation, background, assessment, and recommendation).

- 36% (n= 25) were not comfortable with SBAR or preferred a different method

Question 9: When asked if respondents had seen the updated Bedside Shift Report rack card ?

- 87% (*n*=58) indicated they had not seen it

Question 10: Were the unit specific guides for bedside shift report helpful?

•59% (*n*=55) did not see the unit guides.

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Question 11: When asked if they had viewed the facilities Bedside Shift Report video.

- 66% (*n*=45) had not seen it when it first came out or when the re-education was offered.

Open-Ended Responses

- not wanting to wake the patients
- family disturbing report
- patients asking too many questions

Open-Ended Responses

- lack of comfort in the process
- length of time to complete bedside shift report
- overall lack of training.
- Patient perceptions

Findings Related to Theory

Findings related to Lewin's three-stage change theory, along with Kotter's eight-step change model.

Future Implications

Understand and incorporate perspectives of frontline staff.

Relationship to Professional Practice

Consistent message coming from leadership

Frontline staff mentioned the importance of further re-education

Implications for Social Change

The results of this project may impact patients in a positive manner by providing a better quality of care in this facility.

Recommendations for action

Further studies can include:

- An analysis of which unit having highest non-compliance rate
- An analysis of the type of non-compliance is most frequent in comparison to each unit
- A longitudinal study can be performed to see if this re-education was effective at 6-months and 1-year

Summary of Project / Results

Wealth of lived experiences and data to share with the nursing leadership team.

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Thank you for your time and attention

Questions ?