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Development of a Bedside Shift Report Policy and Guidelines to Assist Nurses with Patient Care

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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

In 2013, the Hospital Consumer Assessment of Healthcare Providers System (HCAHPS), a national, independent metric of patient satisfaction, revealed room for improvement at a teaching hospital in the southeastern section of the United States. This project reports the development and validation of a Bedside Shift Report (BSR) policy, practice guidelines, and associated documentation. Several initiatives, models, and theories informed thinking about this project. The work of Kurt Lewin and the Institute for Healthcare Improvement-Robert Wood Johnson Foundation's joint initiative, Transforming Care at the Bedside, both guided the project in terms of the process of institutional change. SBAR (Situation Background Assessment and Recommendation Technique) was the primary model upon which communication strategies were developed. PDSA (Plan-Do-Study-Act) served as a continuous quality improvement model to inform development of the implementation and evaluation plans. Using these concepts, models, and theories, a project team led by the DNP student reviewed relevant literature and considered institutional contexts and goals in order to develop a new institutional bedside-report (BSR) policy along with practice guidelines to inform operationalization of the BSR policy. Five scholars reviewed these products with expertise in relevant content areas in order to validate essential content; both policy and practice guidelines were revised in accordance with feedback. All related documentation needed to implement the products, along with both an implementation and an evaluation plan, were also developed by the project team. Improved nurse-patient communication holds significant potential to improve patient satisfaction and to promote positive social change across the institutional service population.

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MSN, Walden University, 2012

BSN, University of Alabama, 2008

Project Submitted in Partial Fulfillment

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Dedication

I would like to dedicate this project in honor of my parents Booker and Mary Snedecor

for raising me and training me for such a time as this, and to my beautiful daughter

Ashley, who was always there when my studies became overwhelming.

Acknowledgments

I would like to thank God, my mentor at the practicum hospital, and all of my faculty

committee members who helped me reach this point in my academic career. I am truly

grateful.

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Section 1: Introduction

In 2006, The Joint Commission (TJC) established a safety goal to improve the way nurses communicate with patients and families during hospital care (Riesenberg, Leisch, & Cunningham, 2010). Citing the Institute of Medicine (IOM) Reinbeck and Fitzsimons (2013) assert that communication issues compromises patient safety. Reinbeck and Fitzsimmons recommend that patient information be communicated not only between caregivers but freely with patients and their families.

One of the reasons that TJC developed National Patient Safety Goals (NSPG) was to encourage patients and their families to become active members of their own health care team (Vines, Dupler, Van Son, & Guido, 2014). Patient-family involvement during the change of shift report is a patient safety strategy to help reduce miscommunication between the nurse and the patient-family (Baker, 2010). Most health care consumers are willing to collaborate with their health care providers to become active participants in the care (Caruso, 2007; Vines et al., 2014).

Effective communication is necessary for the delivery of safe and high-quality patient-centered care (Reinbeck & Fitzsimons, 2013). Adequate nurse-patient communication not only signifies a safety aspect within health care, but is also significant from a financial standpoint. When Medicare reimbursement dollars are anticipated health care organizations must explore and refine effective communication methods to provide an exceptional healthcare experience for their patients (Reinbeck & Fitzsimons, 2013). There is a need to provide quality patient care so that patients are satisfied with their care

(Bleustein, 2014). Patient satisfaction hinges on patient-specific characteristics, nurse-patient interaction, and perceived wait times for care to be provided (Bleustein, 2014).

Communication issues in health care can make a difference between life and death. Since TJC (2006) prompted changes in the way that nurses conduct shift reports, there has been more research and criticism on the informational value, length of time recommended for report, standardization, and redundancy of shift report (Kerr et al., 2011; Sexton et al., 2004 as cited in Cornell et al., 2014). Nursing students seldom have the opportunity to practice shift report during clinical, instead they are educated on the standard practice for end-of-shift report in nursing school. Therefore, the unfamiliarity with shift report causes the process to become inconsistent and unstructured in the clinical setting (Hill & Nyce, 2010; Kerr, Lu, McKinlay, & Fuller, 2011, as cited in Cornell, Townsend, Yates, & Vardaman, 2014). To assist with the end of shift hand off report (HOR), nurses are increasingly implementing the handoff at the bedside side. The HOR is a real-time interactive communication tool that involves the off-going frontline nurse (FLN) giving a shift report on the patients for whom he or she was responsible for to the on-coming FLN (Caruso, 2007). Implementing HOR at the patient's bedside which is termed Bedside Shift Report (BSR) is found to be an effective way to engage the patient and their family as part of the care team. BSR is used to achieve the NPSG's requirements to standardize shift report (Caruso, 2007; TJC, 2007). In contrast to BSR, HOR may take place in the nursing station, in a conference room, or anywhere other than the patient's bedside excluding the patient and family (Caruso, 2007). HOR is not patient centered and does not include patient and family engagement (Baker, 2010; Federwisch,

2007**)**. A standardized BSR at the end of a shift will help develop consistency in executing the BSR policy and guidelines that ensure the same process will happen every time with every nurse and patient-family.

Other benefits in BSR are that it helps to improve the accuracy of patient identification (Baker, 2010). The reporting FLN communicates pertinent medical information about the patient in front of the receiving FLN. It is during BSR that the patient can hear their care plans discussed first-hand between FLNs. The medical information reported may consist of, but is not limited to, the patient's medical diagnosis, current condition, new doctors' orders, procedures, and pending procedures. In general as it relates to the project, during BSR the on-coming FLN can get clarification and ask questions concerning the patient's plan of care before the off-going nurse leave the site if the need arises.

Researchers have proven that by using BSR sentinel events which are sometimes a direct result of miscommunication among nurses have shown a decreased (Olson-Sitki, Weitzel, & Glisson, 2013). According to Laws and Amato (2010), the use of BSR improves safety and communication among patients and nurses. BSR can also have a positive influence on how patients and families perceive the quality of health care services (Laws and Amato, 2010). Reinbeck and Fitzsimons (2013) point out that an increase in nurse-patient communication and patient satisfaction has been reported when BSR is implemented on medical-surgical units in acute care hospitals. Researchers have found that BSR reinforces patient satisfaction; promotes nurse accountability, decreases communication errors; and establishes patient trust between the health care provider and

the patient-family (Cains, Dudjak, Hoffman, & Lorenz, 2013; Reinbeck & Fitzsimmons, 2013; Sand-Jecklin & Sherman, 2013, as cited in Vines et al., 2014). Effective communication between nurses is necessary for the delivery of safe and high-quality patient-family centered care and outcomes (Baker, 2010). Because patients and their family members are allowed to provide input regarding their care, it encourages a more positive perception of being part of their own health care team (Caruso, 2007; TJC, 2010). BSR causes nurses to communicate so consumers can participate in the management of their health care (The Centers for Medicare & Medicaid Services, 2013). Nurses, patients and their family members my make queries and provide responses during the shift report as well (Baker, 2010; Federwisch, 2007). The nurse-patient interaction during BSR benefits the FLNs as well as the patients. FLNs can help foster a trusting working relationship with the patient during the report process. BSR can enhances patient satisfaction by the FLN making shift updates on the whiteboard located on the wall of the patient's room, scanning the room for safety and checking the environment equipment during BSR, and making a quick physical check on the patient's intravenous lines and other tubing during BSR (Baker, 2010). Because it is a quick visual check on the patient, the nurse can ensure that the patient is safe and that the room environment is in good condition (Baker, 2010). BSR creates an atmosphere of patient-centeredness, improves nurse-patient communication, and handoff communication between FLNs (Gosdin & Vaughn, 2012; Reinbeck & Fitzsimons, 2013).

The practicum hospital's HOR policy did not require nurses to implement shift report at the bedside with patient-family engagement therefore; it can be 30 minutes or

longer before the on-coming nurse sees the patient. Educating FLNs on the practice of

BSR and patient-family engagement supports excellence in the delivery of care (Jeff,

2013). Moreover, the BSR protocol can be considered an intervention that positively

influences quality patient care and patient satisfaction.

Problem Statement

In 2007, a problem was discovered at the teaching hospital in the southeast part of

the United States. The problem is un-optimized patient satisfaction resulting from an

unstandardized handoff reporting policy. The BSR was a quality improvement effort used

to comply with TJC (2007) requirements for improving the way that nurses communicate

with patients and families and subsequently enhancing the delivery of high-quality

patient-centered healthcare.

The teaching hospital's current HOR policy was last updated in 2007, and is not

in alignment with TJC (2006). NPSGs helps to engage patients and families to become

active participants in their healthcare plan for patient safety and quality care, to improve

the effectiveness of communication among caregivers, manage hand-off

communications, and allow patients-families the opportunities to respond with concerns

and make queries (Baker, 2010). The 2007 HOR policy shows inconsistencies as

evidenced by an unstandardized handoff practice that excludes patient participation.

Traditionally, hospital administrators in the U.S. have focused more on patient

care outcomes and less on feedback related to patient satisfaction with their hospital

experience (Long, 2012). Many hospitals collect patient satisfaction information for

internal use, but now health care consumers can access feedback on how other health care

consumers compare their hospital experience based on a report analyzed by the Hospital

Consumer Assessment of Healthcare Providers and System (HCAHPS) survey. HCAHPS

is a data collection metric tool used to measure and analyze patients' perceptions of their

most recent hospital experience. The survey begins with a phone call to patients or family

members after discharge from hospital. The surveyor uses a questionnaire format to seek

responses on how the patient-family identifies the quality of health care received during

their recent hospital experience. The survey results are then analyzed and posted online

for public reviewing (Centers for Medicare & Medicaid Services [CMS]: HCAHPS,

2013; Studer, Robinson, & Cook, 2010).

HCAHPS reports information online about hospital services locally, regionally,

and nationally. A healthcare consumer can use the information to make intelligent

decisions on which hospital to use (HCAHPS, 2013; Long, 2012; Studer et al., 2010).

HCAHPS is the first to have a national standard for collecting and publicly reporting

results from a survey on the patient's perception of their hospital stay. HCAHPS have

close ties to the practicum hospital's healthcare service reimbursement.

Even though FLNs at the practicum site implemented the 2007 HOP policy as

instructed, they still received low HCAHPS survey scores in patient satisfaction and

nurse-patient communication. The missing element is the fact that patients and family

were not included as a member of the health care team and in the reporting process.

When patients and family are included inconsistencies in the patient progress report are

limited. I believe that an unstandardized HOR practice contributed to the low scores that

FLNs received. When all FLNs practice the same reporting protocol the outcome can

show that those patients are more likely to be satisfied with the hospital experience (CMS: HCAHPS, 2013, Studer et al., 2010).

Purpose Statement

The purpose for the quality improvement DNP project was to develop a BSR policy and practice guidelines, an implementation plan, and evaluation plan. The initial plan of implementation by two pilot medical-surgical units at the practicum hospital takes place first. The project demonstrated how in-service education for FLNs in BSR can close the gap and have a positive impact on HCAHPS nurse-patient communication scores. An increase in nurse-patient communication subsequently revealed an increase in patient satisfaction. Moreover, an increase in nurse-patient communication shows improvement in patient care quality and patient outcomes. BSR standardization will not only increase HCAHPS scores in nurse-patient communication; but can also create an atmosphere where patients-families and FLNs nurses together can improve the safety and quality of care. Patient's involvement in BSR allows patients the opportunity to recognize that their participation can improve the communication relationship with FLNs and impact patient satisfaction (Kelly, 2005). The more innovative medical science becomes, the more complex patient care will become a platform for miscommunication. When patient safety is jeopardized due to inaccurate communication, patients can become dissatisfied with the nursing staff (Reinbeck & Fitzsimons, 2013). Therefore, it is important to communicate in a clear and concise manner during BSR so that the process can remain patient-centered at all times (Reinbeck & Fitzsimons, 2013). BSR is centered

on the patient's behavior and the organizational policies and practices that reinforce the patient-centered behavior.

Goals and Outcomes

The goal for this DNP project was to optimize patient satisfaction. This goal will be measured by using the HCAHPS scores in nurse-patient communication, which also serves as an evaluation outcome for the overall initiative. The outcome will be an increase in HCAHPS nurse-patient communication scores.

The two units at the practicum hospital used to pilot the project nurse-patient communication HCAHPS scores rank an average of 68%. Objectives to achieve the outcomes include implementing shift report at patient's bedside with patient-family participation, making hourly rounds to address pain, assessment of patient elimination needs, positioning the patient, keeping personal items near, and privacy needs. FLNs prepare the patient for a working relationship by explaining the BSR brochure and the inpatient care survey to the patient-family during the admission process. Upon discharge the FLN reiterate instructions to the patient on how to complete the inpatient care survey. The surveys were kept in a locked box for the patient's representative to collect. If a patient is unable to complete the survey, a family member or a patient representative from nursing administration provided assistance. A strategy for FLNs to consistently comply with the BSR practice for patient satisfaction improvement and to increase nurse-patient communication HCAHPS scores is predicated on whether the practicum hospital implements BSR as a policy (Patterson & Wears, 2010).

Nature of the Project

A Quality Improvement (QI) method was used to achieve the project's purpose and goal. This methodology integrated effective communication, patient-family centered healthcare, and cultural competence to inspire a behavior change in the FLNs. FLNs developed nurse-patient communication skills to enhance the delivery of quality health care that subsequently improved patient satisfaction and increased HCAHPS scores (TJC, 2010). The QI approach accommodated the needs of the patients, families, and the community served. There is an international agenda headed by TJC's Provision of Care Treatment and Services; The IOM and The World Health Organization (WHO) that is aimed to improve, standardize, and make provisions for nursing staff education to set BSR handoff practices at the apex of nurse-patient communication (Graham et al., 2013; TJC, 2014**).**

The project plan presents a tailored outline which began with an assemblage of the quality improvement (QI) team. After which, a presentation of literature search results were discussed with stakeholders. Next the development of the BSR in-service education, implementation and evaluation plans was discussed, after which the pilot medical-surgical units began in-service education for improvement efforts. The in-service stressed how imperative it is for all patients to receive the same high-quality care (TJC, 2010). It does not matter the health condition, disability, ethnicity, sexuality, or social economic background present, all patients will receive the same high-quality care. Once nurses on the pilot units completed in-service education and implementation, the team discussed monthly survey reporting to HCAHPS. The data was evaluated by comparing scores from

the previous year to determine if a 20 % increase in nurse-patient communication was achieved.

The nature of the BSR project offers alternatives in team building among FLNs that will signify the priority to comply with the NPSG. The NPSG was designed to improve effectiveness of communication among caregivers, manage hand-off communications, accurately identify patients, and engagement of patient-family participation during BSR (Baker, 2010). The BSR has become a framework for improving safety on medical-surgical units in acute care hospitals, and demonstrates a handoff practice that impacts patient and family participation (Caruso, 2007; Chaboyer et al., 2009).

Assumptions, Delimitations, and Limitations

Nursing shift report is assumed to be the official transfer of the responsibility for patient care to another nurse (Caruso, 2007). However, the shift report may also serve as an outlet for FLN to share emotional issue encountered during the shift (Agency for Healthcare Research and Quality [AHRQ], n.d.). Therefore, alternative methods should be identified so nurses can vent to one another in another setting. Another assumption focuses on the change to BSR being easy, when in reality FLNs may be hesitant and resistant to make a behavior-cultural change. Some nurses may not feel comfortable with giving a report in front of the patient or family. Taking on new nurse practice behaviors can be a challenging experience (AHRQ, n. d.).Whether or not the change to BSR will be cost effective is another assumption that must be clearly defined in order for hospitals to determine viability and make a smooth transition. The educational cost to meet the goal is

contingent on all activities for the program design. This includes the training budget, use of informatics and other technology to support the FLNs' in-service education (American Nurses Association, 2008).

Evidence-based practice (EBP) information on BSRs is the substance used to fill the knowledge gap. The program was designed to be administered to the FLNs on two pilot units with low HCAHPS scores in nurse-patient communication. Online data was collected from the HCAHPS web site.

Limitations

The project had its share of limitations. First, only the student's practicum hospital was used to undertake the project, which probably had a barren on the local context (Chaboyer et al., 2009). Furthermore, there were other QI initiatives introduced during the in-service at the same time the BSR education was administered. The QI initiatives included recording the names of the patient's nurse and other caretakers on a white board located on the wall directly in front of the patient's bed. FLNs made rounds every hour to address pain, bathroom needs, positioning needs, privacy needs (pull curtains), and personal item needs. Another limitation had to do with FLNs buy-in. Cairns et al. (2013) posited FLNs will no doubt voice concerns regarding patient non-compliance with BSR, compromises discussing sensitive issues and confidentiality, complex family dynamics, and time constraints for reporting purposes.

Significance of the Project

Healthcare organizations that fail to standardize a handoff protocol should have concerns about patient satisfaction and safety (Luther, Hammersley, & Chekairi, 2014).

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The shift report was expected to affect patient satisfaction. Nurse concerns included

questions such as: Who takes care of the patients during report? Can patients be without a

nurse for two or three hours a day during office shift report? It is during these times that

incoming and off going nurses are behind closed doors giving and receiving report.

Moreover, patients have complained that it takes too long to see a nurse during shift

change, which reflects negatively in patient satisfaction comments. When report is

implemented away from the patient the off-going nurses are not introducing patients to

the oncoming nurses. Therefore, a breakdown in communication occurs because patients

often will not learn who their FLN is until later (Athwal, Fields, & Wagnell, 2009). A

standardized BSR protocol designed to make provisions for patients to be involved in

their plan of care is a major contribution to nursing practice and policy (Laws & Amato,

2010). Twenty-first century patients have the desire to be updated and active participants

in their plan of care. Currently the practicum hospital does not have a BSR protocol,

therefore stand in non-compliance with one of the key component of the 2007 NPSG for

hospitals established by TJC in 2006 (Laws & Amato, 2010, 2010, TJC, 2014). The DNP

project established policy guidelines for effective communication among nurses and

between nurses and patients. Emphasis was placed on patient satisfaction by including

the healthcare consumer as a member of their healthcare team (Laws & Amato, 2010).

There are communication failures that TJC have identified that are leading causes

of sentinel events in healthcare. Therefore, there is an urgent need for FLNs to adequately

communicate and exchange patient information during BSR to ensure quality care. With

healthcare information available online, radio and television, patient participation in their

plan of care is becoming an expectation of nurses. Health care consumers are knowledgeable and want to be active participants on their healthcare team (Laws & Amato, 2010).

Implications for Social Change

BSR in-service education at the practicum site is a step toward influencing the makings of a health care policy for patient advocacy. Policies change frequently in healthcare to ensure patient safety and the delivery of high-quality care. Therefore, nurses have a responsibility to stay updated on best practices that may contribute to policies changes (Zaccagnini & White, 2011). According to the American Association of Colleges of Nurses (AACN) essentials, nursing practice and policy guidelines emphasizes safety in patient care, patient-centeredness, efficiency, effectiveness, timeliness, and equitability. The new BSR policy will coincide with the hospital's mission, vision, values, and Faith-based culture.

BSR may also become a part of the hospital's orientation for new hire registered nurses (RNs) and new graduate RNs (O'Sullivan, Carter, Marion, Pohl, & Werner, 2005). AACN essential two focalizes on the adoption of a culture of life learning that will enable health organizations to inspire nurses to improve healthcare quality and achieve greater results. Hence, competitive organizations such as the practicum hospital can draw from a learning culture to influence nursing innovations (Zaccagnini & White, 2011).

The inclusion of patient-family engagement is a major factor that gives BSR implications for positive social change. Patients and families are encouraged to "Speak-Up" during BSR (TJC, 2014). TJC developed a "Speak-Up" program to encourage

patients and their families to become informed and active care team members by making queries and voicing concerns about the health care provided for them.

BSR is driven by evidence-based practice (EBP) and has the propensity for social change by becoming a nursing policy (Cohen, 2006). A nursing policy will strengthen BSR for consistent nurse implementation, optimize the quality of patient care delivery, increase patient satisfaction, and increase HCAHPS scores in nurse-patient communication. Therefore, in a quest for social change a combination of expert skills, knowledge, and integration of evidence-based practice is necessary to advance the nursing profession (Zaccagnini & White, 2011).

Summary

FLNs at the practicum hospital implemented HOR as the policy instructed, however HCAPHS quarterly hospital report show a decline in nurse-patient communication scores. The main problem identified with the HOR policy is a failure to instruct FLNs to implement shift report at the patient's bedside and encourage patient-family participation. There is priority to comply with TJC-NPSG for effective communication improvements. A standardized BSR protocol that makes provisions for patients-families to be involved in the plan of care is a major contribution to nursing practice and policy.

Section 2: Background and Context

Introduction

The exclusion of BSR with patient-family participation limits the effectiveness that ensures optimum patient satisfaction with health care. Therefore, patients and their family had no idea what was being discussed during shift report. The 2007 HOR reporting policy at the practicum site did not instruct FLNs to implement shift handoff at the patient's bedside with patient and family engagement. According to researchers, unsafe quality of patient care, inadequate nurse-patient communication, inadequate nurse-to-nurse communication, low patient satisfaction scores, and low HCAHPS scores resulted from patient-family exclusion (Laws & Amato, 2010).

My purpose in carrying out the DNP project was to develop a BSR policy and practice guidelines, an implementation plan, and an evaluation plan in order ultimately to improve HCAHPS nurse-patient communication scores at the practicum site. An increase in nurse-patient communication may subsequently reveal an increase in patient satisfaction (Gregory et al., 2014). The Joint Commission's NPSG's supports BSR as patient-centered, improves nurse communication and patient safety (Gregory et al., 2014).

A major implication for BSR is for FLNs on two pilot units at the practicum hospital to receive BSR in-service education. For this project QI project team developed policy and practice guidelines for training classes in BSR. Training helps to facilitate the delivery of safe, high-quality nursing care, and thereby should increase patient satisfaction and HCAHPS nurse-patient communication scores The in-service will

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prepare nurses to be in compliance with NPSG's to develop and standardized an

approach to the nurse reporting communication process. As a patient safety strategy, the

training requires nurses to engage patient-family's to be active in their own health care

planning (Baker, 2010).

    In Section 2, I will list library databases and search terms that I used in reviewing

the literature. A review of BSR and patient satisfaction studies reinforced the relevance of

the practice problem. The search helped to identified and defined the framework used in

the project, and provide rationale for selection of framework and theories to use.

Literature Search Strategy

An explicit literature search was conducted using published sources for the purpose of locating information for the development of BSR guidelines to facilitate patient satisfaction and increase HCAHPS scores at the practicum hospital. Peer-reviewed literature and books between 1999 and 2014 were used. Literature searches were conducted online using ProQuest, Medline, CINAHL, Ovid Nursing Journals, Google Scholar, and Health and Medical Complete databases and online search tools. Key terms such as *handoff report, bedside shift report, Lewin's model of change, transforming care at the bedside, Hospital Consumer Assessment of Healthcare Providers and System, value-based purchasing, National Patient Safety Goal, situation-background-assessment-recommendation, plan, do, study, act, nurse-patient communication, and patient satisfaction* were used. Information gathered from these sources helped to explicate the need for BSR policy.

Concepts, Models, and Theories

Lewin's Change Model

Lewin's change model was used to implement BSR. The use of Lewin's model provides a rudimentary framework for education and implementation success as it relates to the reporting process (Olson-Sitki et al., 2013). According to Zaccagnini and White (2011), Lewin's model institutes a desired change in individuals. The change can occur as a result of driving forces toward the change or diminishing opposing forces over a series of three phases: unfreezing, moving, and refreezing. The first step is to unfreeze

old nurse reporting behaviors. The unfreezing phase uses strategies to help the FLNs

assess the need for the change to BSR through in-service education. Unfreezing can be

difficult because of the human beings' natural resistance to change (Educational Portal,

2014). In using Lewin's model, the nurses' BSR beliefs and current knowledge level of

BSR, prepares them for a transition to an improved nursing practice level (Educational

Portal, 2014; Zaccagnini & White, 2011).

The moving step (Olson-Sitki et al., 2013) consist of a recognition of the

advantages begin to incorporate the changes by taking on new behaviors (Olson-Sitki et

al., 2013). In the moving step, the focus is on nurse leaders accepting the change to BSR.

The moving step involves the force that empowers the nurses to adopt the concept while

simultaneously minimizing barriers to the change (Olson-Sitki et al., 2013). Once moving

is established, nurses are ready to refreeze new behaviors.

In-service will reinforce refreezing and influence new reporting behaviors and

ways of thinking about shift report (Educational Portal, 2014). Refreezing emulates a

standard daily practice of BSR implementation (Vines et al., 2014). In the refreezing step,

strategies are created for the sustainability of quality outcomes (Parsons & Cornett,

2011). Sustainability for BSR project is achieved when the outcome remains effective

and does not relapsed to its former status for at least a year (Parsons & Cornett, 2011).

BSR procedures for nursing standards for continuing education and annual competency

will be revised annually by the nurse manger to guarantee changes will not be lost

(Educational Portal, 2014; Vines et al., 2014). BSR for new hire nurse orientation

can make nurses aware of the expectations for the hospital's shift reporting

practices. The project team will be expected to hold quarterly meetings for BSR updates

to evaluate the process, share HCAHPS scores, receive feedback from FLNs, and identify

concerns and unresolved issues for up to one year (Caruso, 2007; Olson-Sitki, 2013).

In the refreezing step, strategies are created for the sustainability of quality

outcomes (Parsons & Cornett, 2011). Sustainability is achieved when the outcome can

remain effective and has not relapsed to its former status for at least one year (Parsons &

Cornett, 2011). In this project, refreezing will occur when BSR has become a standard

daily practice that FLNs implement at every change of shift report (Vines et al., 2014).

New behaviors are achieved by refreezing the desired changes.

Transforming Care at the Bedside

The transforming care at the bedside (TCAB) concept was used to implement a

smooth transition and institute a different reporting culture. TCAB is a national program

created by Robert Wood Johnson in collaboration with Institute for Healthcare

Improvement to improve the quality and safety of patient care on medical-surgical units

(Burke & McLaughlin, 2013). This concept leads nurses through the process of

implementing a new system of care values. The learners discussed values that are

centered on the patient's healing environment, as improving communication is critical to

achieving this aim. Nurses describe three major initiatives to the learners implementing a

safety huddle at the start of the shift, moving report to the bedside, and stablishing nurse-

physician intentional rounds (Chapman, 2009). TCAB supports bedside FLNs who are

encouraged to identify practice problems and make the necessary change toward

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improving the safety and quality of care (Burke & McLaughlin, 2013). TCAB provides

the education and teamwork to create a system that empowers FLNs and enables patients

to take part in their plan of care. The quality improvement effort to increase

communication through the use of BSR will take some time, but it can be accomplished

(Chapman, 2009). By using TCAB tenets in my project development, I hope to elicit a

sustained culture of delivering reliable, patient-centered care.

Situation-Background-Assessment-Recommendation

Situation-Background-Assessment-Recommendation (SBAR) has been adopted

by nurses to enhance prompt accurate communication during the reporting process.

SBAR enables FLNs to stay focused during BSR nurse dialogue. The information

provided by SBAR is intended to be relevant and an essential instrumental in framing

conversations held in front of patients and families (Baker, 2010). The technique aids the

off going FLN to communicate important patient information to oncoming FLNS, and it

helps FLNs to better absorb information (Baker, 2010). In using SBAR there is no need

for FLNs to give report on their patient off the "top-of-their-head" (Cornell et al., 2014).

SBAR enables FLNs to stay focused in giving the patient's situation background,

assessment and recommendation during report. The information provided with the help of

SBAR is intended to be relevant and essential (Cornell et al., 2014). By using the SBAR

technique to prioritize and guide BSR, nurses stay on task. SBAR implementation for

BSR establishes a shorter report time. According to Cornell et al. (2014), nurses who

used the technique were able to lessen their patient reporting time from 119 seconds to 58

seconds (Cornell et al., 2014). The SBAR technique

not only increases shift turnover time, but improves nurse and patient communication.

Plan-Do-Study-Act

Plan-Do-Study-Act (P-D-S-A) was used as framework for the BSR project. The concept is appropriate in that the tool connects performance improvements with "defining, tracking and evaluating" change (Cairns et al, 2013). The P-D-S-A tool connects performance improvements with "defining, tracking and evaluating" change (Cairns et al., 2013). This improvement model's foundation is based on doing the right thing every time for the patient (AHRQ, 2013; Cairns et al., 2013).

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BSR Relevance to Nursing Practice

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A review of the practicum hospital's reporting policy revealed the policy was last updated in 2007. Problems identified with the HOR policy consist of failure to instruct FLNs to implement shift report at the patient's bedside, failure to encourage patient-family participation during report, and failure to insert strategies to meet the patient's communication needs such as hourly rounding and updating the communication white boards in the patient's room.

EBP has shown that when shift report is implemented at the patient's bedside, nurse-patient communication improves (Reinbeck & Fitzsimons, 2013). Therefore, developing a new policy and practice guidelines for BSR promotes quality care that ensures an increase in patient satisfaction, and increases communication between the FLN and patient-family (Reinbeck & Fitzsimons, 2013). The BSR project was used to identify a national patient safety objective to improve communication in the clinical

setting and to standardize handoff. Lewin's change model, SBAR, TCAB and PDSA models were used to assist the FLNs in-service education for transition toward consistent implementation of BSR. Writing and implementing evidence-based guidelines for quality improvement efforts are rudimental strategies for 21st century patient-centered health care.

BSR Ties to HCAPHS

A significant need to change the hospital's 2007 HOR process was necessary for quality improvements to be made. First, there is a nurse-patient communication problem at the practicum site as evident by publicly documented low HCAHPS scores. Secondly, the low nurse-patient communication scores at the practicum site make way for low patient satisfaction scores. The national HCAPHS survey is compiled by Professional Research Consultants. It was developed by AHRQ and the CMS to show the patient's perception of the hospital's customer service in healthcare delivery (HCAHPS, 2012, 2014; Radtke, 2013). There are 32 survey questions with 21 items of which encompasses aspects that are critical to the hospital stay (Medicare Hospital Compare, 2014). Four screening questions are used to move patients to the appropriate questions for them, and seven demographic questions to adjust the patient mix for analytical reasons. HCAHPS currently reports results for six composite topics, two individual topics, and two global topics (Medicare Hospital Compare, 2014; Studer et al., 2010).

The survey allows objective and meaningful comparisons on topics and tasks that patients and their families deem important to a hospital stay. The survey basically wants to know how often did the healthcare professionals carried out these important tasks for

the patients (HCAHPS Fact, 2013). The survey identifies how patients rated their hospital experience based on queries such as how well did the nurse communicate with you in a way that you could understand (HCAHPS, 2014; Studer et al, 2010)? This is one of the reasons why a policy with full implementation of BSR with patient-family engagement is significant. The average patient in the hospital will consider most hospital staff taking care of them a resource person who can answer their questions. Therefore, with a BSR policy in place, all hospital personnel who have direct patient contact is made aware of the hospital's BSR protocol and the HCAHPS survey results that it reflects.

CMS and HCAHPS take steps to assure that the survey is actionable, practical, and creditable (HCAHPS Fact, 2013). Information for HCAHPS scoring is received during a random phone survey after patients are discharged from the hospital (HCAHPS, 2014; Studer et al., 2010). Patients respond to question that gives the surveyors insight on how they perceived their care during their recent hospital experience. Therefore, the reporting of HCAHPS survey results creates an incentive for the practicum hospital to make improvements to enhance nurse-patient communication. FLNs must be educated on how the hospital reimbursements are closely tied to HCAHPS survey results. The survey results are analyzed and posted online for public reviewing (HCAHPS, 2012; 2014). HCAHPS scores are easily accessible online for the public to view and decide whether to seek healthcare service at a particular hospital in question. Public reporting survey results along should motivate hospitals to hone their customer relation skills to deliver quality healthcare (HCAHPS, 2014).

Until HCAHPS came along, the nation's healthcare system did not have a national standard for collecting and publicly reporting information on a patient's hospital experience with healthcare (HCAHPS, 2012). Since 2008, HCAHPS has allowed valid comparisons to be made across hospitals locally, regionally and nationally. In March 2010, the Patient Protection and Affordable Care Act sign into law the urgency for national healthcare providers to deliver high quality, and patient-centered care. According to Reinbeck and Fitzsimons (2013) HCAHPS scores have shown that BSR has a positive impact on how patients' rate nursing communication during their hospital experience. The practicum hospital uses their own measuring tool whereby information is collected for patient satisfaction purposes as well as HCAHPS reporting.

BSR and Value-Based-Purchasing (VBP)

In 2012, The CMS implemented a pay-for-performance program and named it Value Based Purchasing [VBP] (HCAHPS, 2014; Schroeder, 2013; Shoemaker, 2011). The ground-breaking program is an incentive for participating hospitals to provide high-quality care. VBP allows a hospital to be paid for the quality of patient care provided, and not the quantity (CMS, 2014; Szablowski, 2014). The impact of VBP was felt by hospitals nationwide in the 2013 fiscal year (Schroeder, 2013).VBP rewarded hospitals that demonstrate a higher performance in the delivery of high-quality care by redistributing Medicare payments among them. Hospitals with lower performance received a lesser proportion of the reimbursement (Shoemaker, 2011). HCAHPS survey results and CMS value-based-purchasing initiative program both play important roles in hospital reimbursements (Studer et al., 2010). A change in the way hospitals are paid can

speak volumes for improvements in healthcare quality and keep patients healthier at the same (CMS, 2014). The teaching hospital will have a greater opportunity for health care reimbursement when BSR is practiced (Studer et al., 2010).

According to Singleton (2005) a study done on a 32-bed surgical unit at Banner Desert Medical Center revealed benefits from BSR implementation. The researcher reported that EBP indicates BSR kept the health care consumers better informed. EBP suggests that patients and families who participate in BSR are more pleased with their care, have less staff complaints, and are motivated to follow patient teaching instructions (Anderson & Mangino, 2006; Singleton, 2005).

An acute care community hospital with over 500 beds demonstrated a need to implement BSR. FLNs wanted to hone their skills to deliver safe-high-quality care in efforts to improve the patients' hospital's experience (Reinbeck & Fitzsimons, 2013).Transferring report to the patient's bedside allowed FLNs and patients to form a better nurse-patient communication relationship. Moreover, report implemented at the patient's bedside was patient-centered which had a major impact on patient satisfaction scores (Reinbeck & Fitzsimons, 2013). The BSR implementation at the community hospital reduced nurse's time spent away from the patient's bedside. Patients' safety checks were implemented during BSR whereby resulting in a smooth reporting process. According to Reinbeck and Fitzsimons (2013), BSRs have shown patients to have a more positive perception on nurse-patient communication and shows increases in HCAHPS scores.

Evidence described by Cairns, Dudjak, Hoffman, and Lorenz (2013) revealed a practice problem in an academic hospital in Pennsylvania. The practice problem involved disorganized and inconsistent HOR. The problem investigator developed an anonymous survey for the project. The questions sought information on how the nurses felt about their current shift reporting practices and the plan to implement walking rounds during HOR (Cairns et al., 2013). The project results confirmed a direct relationship between walking rounds during HOR. The combination had a positive effect on patients. Findings showed that patients were pleased to be included in their treatment plan of care during shift report. The nurse's call light usage during change of shift decreased; and there was an increase in patient satisfaction scores (Cairns et al., 2013). Nurses reported a feeling of improved confidence when patients are visualized while receiving report (Cairns et al., 2013).

In 2013, Jeffs et al. reported on a similar practice problem in an inner-city acute care hospital. The researcher wanted to explore the nurses' perceptions and experiences related to BSR prior implementation. Nurses were interviewed and analyzed "using directed content analysis" (Jeffs et al., 2013). The study revealed that the nurses' felt comfortable about making the change to BSR. According to Jeffs et al. (2013) the study's results showed BSR themes such as patient visualization, medical error interception, prioritizing care, and clarification of nursing report from the off-going FLN. Patient engagement was shown to be exemplary of patient-family centered nursing. Patient participation during BSR was determined a constant (Jeffs et al., 2013; Sand-Jecklin, & Sherman, 2013). Jeffs et al. (2013) reported that patients expressed that BSR

gave them an opportunity to connect personally with their nurses, correct misinformation communicated during BSR, gain insight in their status, and choose their level of engagement in BSR.

Local Background and Context

While riding on the back of Boyer's Model with overlapping dimensions in scholarship of discovery, integration, application, and teaching, the student believes the FLNs at the practicum site will be endowed with the BSR concept post implementation (Starck, 1996). The practice problem identified with the 2007 handoff policy is a failure to instruct FLNs to implement shift report at the patient's bedside and to encourage patient-family participation during handoff. In order to reinforce an appropriate shift handoff and ensure quality improvements at the practicum site, the student was required to write new policy guidelines for BSR to educate FLNs.

The practicum hospital is part of a faith-based health care system. The system has a network of specialty-care, and primary clinics with over 38 locations statewide (BHS, 2014). The health system is known as one of the Southeast's largest employers. The organization employs over 4,500 employees, over 800 affiliated physicians, and treats nearly 340,000 patients across four hospital campuses. The practicum site's mission is "to provide better health for more people by empowering our patients to achieve their best health through coordinated care, delivered at the right place at the right time" (BHS, 2014). The practicum hospital is committed to "reinventing the way health care is delivered by applying innovative solutions and technologies to advance safety, value, and convenience in each patient experience" (BHS, 2014).The practicum Health System

participates with HCAPHS' national requirements (BHS, 2014; Studer et al., 2010). The online public information may be retrieved from Hopitalcompare.hhs.gov (BHS, 2014; Studer et al., 2010).

Definitions

Hand-off report (HOR): The process where patient information is communicated in a consistent manner from one provider or team of providers to another (Caruso, 2007).

Bedside shift report (BSR): The process where an off-going nurse gives a patient report at the end of shift to the incoming nurse at the patient's bedside; includes patient and family engagement during report (Gregory et al., 2014; Jeffs et al., 2013).

Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS): A national survey and metric system used by hospitals to measure the healthcare consumer's perception of their recent hospital experience based on ten important hospitals quality topics (Studer, 2010, The Hospital Consumer Assessment of Healthcare Providers and System [HCAHPS], 2012).

Lewin's Model: A three step model to change: unfreezing, changing or moving, and refreezing (Olson-Sitki et al., 2013).

Transforming Care at the Bedside (TCAB): A concept designed to empower the nurses to initiate and institute changes to improve the quality of care. Care values are centered on a patient-centered healing environment and improving nurse-patient communication inpatient care (Burke & McLaughlin, 2013).

National Patient Safety Goal (NPSG): A program designed by The Joint

Commission to help accredited organizations address patient safety in specific areas of

concern (The Joint Commission [TJC], 2015).

Plan-Do-Study-Act (PDSA): a recognized method used to improve performance

by incorporating "tracking, defining, and evaluating" a practice change (Cairns et al.,

2013).

Situation-Background-Assessment-Recommendation (SBAR), a model used to

improve communication in urgent situations, known to make communication predictable

and consistent (Cornell et al., 2014).

The BSR Project Advances Nursing Practice

The AACN, the IOM, and TJC have called for a conceptualizing in order to meet

the needs of America's healthcare delivery system and subsequently maintain safe, high-

quality, and ethical practices (Zaccagnini & White, 2011). The second DNP essential

which includes four essential components are the foundation on which this project stands.

The essential points to understanding the principles of practice management consist of the

ability to assess practice policies and procedures, proficiency in quality improvement,

and creating and sustaining changes at the organizational and policy levels (Zaccagnini &

White, 2011). Prior to the BSR project, the practicum hospital FLNs were following an

unstructured handoff policy that fostered low HCAHPS scores in nurse-patient

communication. The new policy guidelines bring consistency to the reporting process in

the clinical setting.

Role of the DNP Student

The practicum mentor for the DNP student was eager to get the policy written and implemented once they were made aware of how the policy deviated from TJC requirements and NPSGs. The DNP student leading the proposed project at the practicum hospital has a Master in Nursing Education (MSN) and over 30 years' experience in bedside nursing. As a nurse educator and change agent, an understanding of the needs of the learner's (FLNs) environment is crucial as it relates to improving their delivery of health care. The student's role for the project is one of a developmental scholarly consultant for BRS policy and guidelines.

Role of the Project Team

The student collaborated with stakeholders who were involved in the entire planning process and support the project's goal (Hodges & Videto, 2011). Involving stakeholders and the target population (FLNs) in the planning and implementation phase is essential to the project success. Using an organizational approach, a quality improvement project team was created to standardize the protocol. The project team consisted of Chief Nursing Officer (CNO), Director of Nursing (DON), Quality Improvement (QI) Director, Clinical Nurse Leader (CNL), Nurse Manager (NM), Frontline Nurse (FLN), and DNP Student. The final project will be a BSR policy and practice guidelines development by the team to educate the FLNs at the practicum site in BSR. The guidelines will be validated by external scholars and plans for implementation and evaluation will be developed.

The project team members will be individuals who are valuable, respected, represents the FLNs, and the practicum hospital. Much consideration will be placed on the roles of the team members and how often the team will meet. The members will have knowledge of the nurses on the pilot unit's attitudes and their assets. The project team will comprise invested individuals who will bring resources and skills for the project's success (Hodges &Videto, 2011). The CNO and DON will organize available resources for the project, and oversee the project during implementation and evaluation. The QI director will present improvement results to CNO, DON and collaborate with the CNO, DON, and CNL for guidelines to become a policy. CNL and NM will educate a FLN trainer and charge nurses on BSR education for the project prior to project completion. After which, the NM will be mainly responsible for implementation and evaluation. The FLN trainer and charge nurses will serve as continuous BSR super-users.

Summary

Public reporting survey results should motivate hospitals to hone the quality of health care provided. HCAHPS scores can be found online for the public to see and decide whether to seek healthcare service at a particular hospital in question. Multiple studies have been done that reveals benefits from BSR implementation. Lewin's change model was used as a guide to help staff make the change in BSR implementation. The tools provided a rudimental framework for a successful implementation in the end of shift reports. TCAB, PDSA, and SBAR were used to improve the quality and safety of patient care during the BSR process. The learners were able to discuss the values that centered on the patient's healing environment and improving communication. Three major

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initiatives the nurses will describe during implementation are safety huddles prior to BSR, implementing report at the patient's bedside, and establishing nurse-physician intentional rounds. In order to reinforce an appropriate shift handoff and ensure quality nurse-patient communication improvements at the practicum site, I wrote new guidelines for BSR to educate nurses.

Section 3: Collection and Analysis of Evidence

Introduction

The practice problem is un-optimized patient satisfaction. The purpose of this quality improvement project was to develop BSR guidelines for in-service education along with an implementation and evaluation plan for two pilot medical-surgical units at the practicum hospital. In implementing and evaluating the BSR project, I will assume the role of scholar consultant. In this section, I included creating my protocol for assembling a project team, providing in-service education to nursing staff at the practicum hospital, and developing project component to undertake during project.

Practice-Focused Question

The problem motivating my DNP project is un-optimized HCAPHS scores in nurse-patient communication. I believe the low nurse-patient scores resulted from an unstandardized handoff reporting practice. The exclusion of BSR with patient-family participation may be a significant cause of the practice problem (Caruso, 2007; (Kelly, 2005). The 2007 HOR policy practice does not require that FLNs engage patients or their family members in the shift reporting communication process. The practicum hospital's 2007 HOR policy did not require FLNs to include the patients or family members in the

reporting process. Therefore, the 2007 HOR is the substratum that failed to practice report at the patient's bedside. I believe, the omission of BSR with patient-family participation leads to poor nurse-patient communication.

The purpose of this DNP project was to develop BSR policy and practice guidelines, an implementation plan, and an evaluation plan to prove that using BSR will elicit an increase in HCAHPS nurse-patient communication scores. The increase in nurse-patient communication may subsequently reveal an increase in patient satisfaction. Moreover, an increase in nurse-patient communication shows improvement in patient care quality and patient outcomes. BSR standardization increases HCAHPS scores in nurse-patient communication, and creates an atmosphere where patient, families and nurses together can improve the safety and quality of care. Patient-family involvement in BSR allows them the opportunity to recognize that their participation can improve the communication relationship with FLNs and impact patient satisfaction (Kelly, 2005). The more innovative medical science becomes, the more complex patient care becomes, which increases the possibilities for miscommunication (Kelly, 2005).

The goal for this DNP project was to optimize HCAHPS scores in nurse-patient communication. Other outcomes that may come as a result of BSR policy and guideline implementation include improvements in nurse-to-nurse communication, increases in patient satisfaction scores, and decreases in falls during the end-of-shift report. The goal of BSR may have a positive effect on the entire hospital (Radtke, 2013).

Sources of Evidence

Published Outcomes and Research

BSR is a complex process where the presentation of the practice problem and possible solutions is extremely important to promote a buy-in with key stakeholders. EBP literature was a type of evidence used to collected and analyzed while investigating the practice-focused question. EBP informed the QI project team on BSR's strengths and weaknesses to promote change (De Los Reyes & Kazdin, 2008, as cited in Rhoades, 2011). The new knowledge supported the QI team's decision on what specific method or approach to use for BSR implementation. The literature reviewed drove the decision-making process for team members to develop a BSR policy with practice guidelines that in hopes to strengthen patient advocacy.

Evidence Generated for the Doctoral Project

I followed these steps in undertaking the BSR quality improvement project:

1. Assemble quality improvement team members.

2.   Present and guide project team in reviewing relevant literature.

3. Develop policy and practice guidelines using evidence-based literature.

4. Validate content of policy and practice guidelines using scholars with expertise in this area.

5. Develop implementation plan.

6. Develop evaluation plan.

Program Development

Once the project team and stakeholders complete the literature review needed to

execute the project, the training program was created. Team members agreed to revise the

current handoff policy to accommodate the upgrade needed for BSR to be successful. The

program is developed to present new initiatives to standardize end of shift report that will

include patient and family engagement. Equipment and supplies consisted of a nurse

patient assignment sheet, an updated patient care activity record, a BSR check-off sheet,

BSR brochure, BSR work sheet, a portable computer work station, and a dry erase

marker. All direct care FLNs who perform BSR, are responsible for updating the white

boards, and giving and receiving end of shift report at the patient's bedside.

Content Validation

Validation is important to the BSR program in that it responds to TJC's national

patient safety goal to manage the communications of hand off. Furthermore, validation

confirmed the project's reasonableness. The practicum hospital's Patient Care Practice

Committee and Quality Improvement Committee reviewed the primary product for the

BSR program. The completed program was then shared with five scholars with content

expertise and revised according to feedback gleaned by this content validation procedure.

BSR Implementation Plans

Development of the BSR policy implementation plan requires certain designated

activities for effective implementation. The policy implementation plan constituted

reviewing the policy and determining what activities are essential for future

sustainability. While the project team determined how to proceed with the

implementation, the following plans were presented as a starting point for further

discussion.

The undertakings and developmental planning for policy implementation

produced secondary products executed by the NM upon QI project team's approval and

project completion. The student functioned in the role of developmental scholar-

consultant, and the QI project team collaborated and executed the actual plan for

implementation and evaluation. The QI team recognized the need to implement BSR for

the purposes of reporting adequate patient information and increasing patient satisfaction

to improve HCAPHS scores in nurse-patient communication. I believe that moving report

to the bedside and encouraging patient and family participation will foster a sense of

respect and trust between the patient and nurses. The implementation plan was contingent

on activities that ensured continuous future BSR policy implementation. To successfully

implement the process and engage the FLNs, all direct care nurses attended a two day, six

hour in-service educational session to learn the various aspects of BSR critical elements.

With the exception of certain needs related to unit variations, the same information was

presented to educate nursing technicians. The education included evidence supporting

BSR, why the change is necessary and guided by Lewin's change model. Implementation

barriers were also included to show how challenges can interrupt and hinder goal

achievements. This is where buy-in from stakeholders was used to lead and mentor FLNs

toward creating a culture that would accept the change to BSR. This process was

measured by the QI project team during meetings for the development of policy

implementation planning. The QI project team:

1. Selected two medical surgical units to pilot the BSR project.

2. Selected a FLN super user and charge nurses from pilot units to receive in-service education for training purposes.

3. Decided on a start date to implement the pilot practice guidelines.

4. Evaluated the project outcome.

Two pilot medical-surgical units initiated the in-service education for improvement efforts. The in-service stressed that all patients must receive the same high-quality care (TJC, 2010). To foster learning a BSR PowerPoint presentation was created by the student. Also utilized in this project were a BSR brochure, a work sheet that was used in the clinical setting, training plans for BSR, step-by-step instructions on conducting BSR, SBAR, and the PDSA model for action oriented learning.

Evaluation Plan

The QI project team was determined how to precede with the evaluation, therefore tentative plans were presented as a starting point for further discussion. The BSR project evaluation plan will includes HCAHPS scores from the previous year to identify a base line. HCAHPS scores for the two pilot units will be observed and recorded for 12 months. The PDSA will be used to monitor improvements and re-evaluate the program (Baker, 2010).

The project team was also educated in project monitoring, outcome, and evaluation the methods. Once in-service education and implementation for the two pilot units were completed, the team focused on the urgency in collecting all in-patient surveys. This process required that multiple QI team meetings take place within a certain

time frame. The team discussed meeting times to compare in-patient surveys and HCAHPS results. The data was evaluated by comparing scores from the previous year to measure the percentage increase in nurse-patient communication. The evaluation was ongoing throughout the project. HCAHPS patient satisfaction scores will be monitored through the year to detect barriers and challenges for tweaking purposes that may ensure quality service. The evaluation metrics will occur after a year of change when the previous year's scores are compared to the current year.

Time Line and Resources

The time required developing and educating the FLNs on two pilot medical surgical units was four months. After which, a 12 month post implementation evaluation to establish if the goals were met will take place. The QI team will meet once a week for one hour the first three weeks to collaborate and review the latest literature related to the project. Lewin's change model, TCAB, SBAR, and PDSA will be reviewed as well. The meetings will also be a time to discuss current in-patient surveys and HCAHPS report scores, and specific barriers to implementation and evaluation. In addition, the team will decide tentatively on a time to go-live with the implementation plan for FLNs throughout the hospital. The primary product for the BSR quality improvement project is the BSR practice guidelines that have the potential to become hospital policy. The student will not collect data during the DNP Project. The practice guidelines for the DNP project will be implemented after the student has fulfilled the developmental planning role. Secondary products needed to complete the overall project, such as implementation and evaluation plans, will be conducted by the nurse manager and charges nurse. The two pilot units will

initially be educated on BSR. Long term plans are to educate all front line bedside RNs in the hospital within a six month time frame after the in-service education, provide training, and the complete the pilot unit implementation and follow-up before undertaking full scale application. A written policy with guidelines will standardize BSR practice and influence project freeze.

A time line to develop the BSR policy and guidelines, and train/educate the pilot unit super users and CNs will take four months. A post implementation evaluation to analysis whether BSR met the goal can take up to 12 months. Resource needs will vary and are contingent on the scope of what the in-service education will consist of. Expenses for the first in-service education will require:

- A PowerPoint presentation.

- Evidence based practice articles and/or –handouts.

- BSR policy and guidelines.

- A BSR brochure.

- A Bedside Shift Report work sheet.

- An implementation handout.

- An evaluation handout.

- BSR role play/reenactment of what BSR will look like.

- White boards and markers for daily updates and other pertinent information (presently on walls in every patient's room).

Summary

Section 3 restated the problem, purpose and goals for the practice problem. The approach was identified and justified. The student functioned in the role of scholar consultant and collaborated with stakeholders that support the project's goal. The project team members included individuals who are valuable, respected, and who represent the FLNs and the practicum hospital. The student did not collect data during the DNP Project. The primary product for the DNP project was implemented after the student fulfilled the developmental planning role. Secondary products needed to complete overall project such as implementation and evaluation plans were conducted by the nurse manager and charges nurse. The undertakings and development planning of products for implementation and evaluation were executed by the unit managers upon QI approval and project completion. The QI team met once a week for one hour the first three weeks to collaborate, develop and approve guidelines. Resource needs varied and were contingent on the scope of what will be done for in-service education. Data collection for evaluation was completed by the nurse manager and was ongoing throughout the project on quarterly bases. Patient satisfaction and HCAHPS scores will be monitored in the coming year(s) to detect barriers and challenges for tweaking purposes that may ensure quality service. The evaluation metrics will ensue after a year of change when the previous year's scores are compared to the current year.

Section 4: Findings and Recommendations

My intention in designing this DNP project was to design a BSR policy and an implementation and evaluation plan to improve patient satisfaction at the practicum hospital. By developing a BSR policy and practice guidelines, I hoped to improve communication by engaging the patient-family during nurses' reporting process. As Radtke (2013) observed, increasing communication between the patient-family and the nursing staff increases patient satisfaction. The unique reporting process includes the patient, family, and individuals whom the patient deems to be a part of his or her care. Ultimately, I hoped that implementation of the BSR project will result in an increase in practicum hospital nurses' HCAHPS scores (Radtke 2013) in the category of nurse-patient communication. A 20% increase in HCAHPS nurse-patient communication scores will serve as an indication that the implementation plan was successful and improved hospital reputation.

Findings and Implications

The development of the BSR project was an attempt to increase HCAHPS scores in nurse-patient communication. The increase will reflect the level of health care delivered on the two pilot units. A measured 20% increase in HCAHPS nurse-patient communication scores will indicate communication has improved.

Policy Implications

Implications for the BSR policy at the practicum site are based on a hypothesis supported by literature reviews and evidence-based practice. The BSR policy and guidelines supported TJC recommendations to standardize report handoff and transform

care at the bedside. The BSR is a strategy used to improve the quality of care and in doing so patients will become more satisfied with their care. Nurse-patient communication can improve when FLNs use patient engagements such as reflection during BSR. BSR was combined with written, nonverbal, and verbal forms of communication to transfer information to the patient-family during report (Chaboyer et al., 2009). Caruso (2007) reported that BSR could weed out unimportant jargon during the report. A policy change for the practicum hospital will comply with TJC recommendations to correctly identify patients and improve staff communication (TJC, 2013). Furthermore, BSR can reinforce patient-family perception of care and satisfaction hence heightening the hospital's reimbursement rates (Sturder, 2010).

Patient satisfaction scores will improve significantly after the implementation of BSR (Gregory et al., 2014). Researchers found that a significant variation occurs with BSR; therefore continued monitoring and periodic reinforcements support by management are needed for BSR to be successful (Gregory et al., 2014).

Practice Implications

BSR consists of critical principles that can enhance the patient overall hospital experience. Shift report can be complex therefore it must be built around complex concepts. TCAB is an evolutionary approach that was implemented to ensure communication between FLNs and patients, and to enhance the nurse-patient relationship to reduce medical errors. Nurses can assess the room's environment, intravenous line, drains and other devices during the process (Gregory et al., 2014).

When BSR is practiced at the patient bedside, it contributes to patient satisfaction, patient-centeredness, and nurse empowerment aftercare (Anderson & Mangino, 2006). Patient engagement during report keeps them updated on their care. Thus, patients feel a part of the health care team and are more likely to follow recommendations and comply with aftercare (Anderson & Mangino, 2006). As a result, satisfied patients may become loyal healthcare consumers at the practicum hospital, return to the facility for future care, and recommend the hospital to others (Anderson & Mangino, 2006).

Social Change Implications

Creating social change with BSR is an opportunity to recognize that patients and families are major players on the health care team and are welcomed to participate in their care. Before BSR, nurses had a routine of giving a report to each other in an office. There is a shift from a private nurse-centered report to a patient-center report that takes place at the patient's bedside. The switch helps the patient and the family understand the plan of care better and what outcomes to expect.

Nurses and physicians have reported an increased in satisfaction as this can decrease turnover costs, and subsequently have a positive effect on hospital finances (Gregory et al., 2014). Traditional reporting techniques can no longer meet the 21st-century patients' needs. Financial constraints, market forces, and consumer demands require that patients become involved and interactive in their healthcare (Anderson & Mangino, 2006). BSR helps the patient to connect with collaborative decision making, therefore, provides an opportunity for needs to be met and increases patient satisfaction (Anderson & Mangino, 2006).

Strength and Limitations of the Project

A challenge at the practicum hospital is for nurse leaders to choose a model for their organization and patient population to sustain optimal patient satisfaction. More research is needed to determine the longitudinal results of bedside shift report (Gregory et al., 2014). Another limitation is patient confidentiality. Confidentiality is a great concern with FLNs in reference to BSR. Violating HIPPA is a major concern with nurses. A violation can occur when giving report with roommate and their visitors present. Nurses have voiced apprehension when it comes to requesting visitors to leave the room even with the patient's permission (Anderson & Mangino, 2006).

On the other hand, the BSR project shows that a standardized shift report protocol will increase patient satisfaction (Caruso, 2007; Kelly, 2005; Laws & Amato, 2010). With the implementation of BSR also comes an increase in patient health care literacy. Health care literacy involves a person ability to understand and process their healthcare information enough to make sound decisions. Therefore, nurses must be abreast and embrace the responsibility to present medical information and teach the patient during BSR.

Summary

The development of the BSR project was an attempt to increase HCAHPS scores in nurse-patient communication. A measured 20% increase in HCAHPS nurse-patient communication scores will indicate communication has improved. Patient satisfaction scores will improve significantly after the implementation of BSR (Gregory et al., 2014).

Abstract

In 2013, the Hospital Consumer Assessment of Healthcare Providers System (HCAHPS),

a national, independent metric of patient satisfaction, revealed room for improvement at a

teaching hospital in the southeastern section of the United States. This project reports the

development and validation of a Bedside Shift Report (BSR) policy, practice guidelines,

and associated documentation. Several initiatives, models, and theories informed thinking

about this project. The work of Kurt Lewin and the Institute for Healthcare Improvement-

Robert Wood Johnson Foundation's joint initiative, Transforming Care at the Bedside,

both guided the project in terms of the process of institutional change. SBAR (Situation

Background Assessment and Recommendation Technique) was the primary model upon

which communication strategies were developed. PDSA (Plan-Do-Study-Act) served as a

continuous quality improvement model to inform development of the implementation and

evaluation plans. Using these concepts, models, and theories, a project team led by the

DNP student reviewed relevant literature and considered institutional contexts and goals

in order to develop a new institutional bedside-report (BSR) policy along with practice

guidelines to inform operationalization of the BSR policy. Five scholars reviewed these

products with expertise in relevant content areas in order to validate essential content;

both policy and practice guidelines were revised in accordance with feedback. All related

documentation needed to implement the products, along with both an implementation and

an evaluation plan, were also developed by the project team. Improved nurse-patient

communication holds significant potential to improve patient satisfaction and to promote

positive social change across the institutional service population.

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Section 5: Dissemination Plan

Scope and Delimitations

The proposed BSR project was developed, implemented and evaluated to optimize patient satisfaction. After 12 months of BSR implementation, the HCAHPS scores are compared to the previous year. The program's success will be measured by a noted 20 % increase in HCAHPS nurse-patient communication after the comparison. The evaluation of patient's satisfaction using resulted HCAHPS scores will indicate how the patients and families perceived their care when nurses included them in their plan of care at the bedside.

Primary Project Products

BSR Policy

The BSR policy, BSR brochure, and BSR worksheet are the three primary products developed by the project team for BSR implementation. These products are also used as part of the dissemination to other units within the hospital. Development of the BSR policy is the first of the primary products for the project (see Appendix A). The policy effort will focus on providing standards and guidance for FLNs to use during the implementation process (Dowling et al. 1996, Sakr et al. 1999 as cited in Manias & Street, 2000). There are specific guidelines the policy will used to: optimize patient satisfaction; increase HCAHPS scores in the category of nurse-patient communication; and deliver high-quality patient care. The BSR policy and guidelines will enforce a consistent standardization of shift report with patient/family engagement. The ultimate goal of the policy is to optimize patient satisfaction measured by a 20% increase in

HCAHPS nurse-patient communication scores. The BSR policy and guidelines will allow

nurses to become transparent and encourage patient and family engagement thereby,

resulting in a better nurse-patient relationship. Moreover, nurses will learn to embrace the

value of BSR as it fosters a sense of teamwork (Reinbeck & Fitzsimons, 2013).

BSR Brochure

On the day of admission, the FLN will invite the patient to participate in a

discussion that will explain the BSR brochure (see Appendix B). The BSR brochure is

the second primary product that helps to explain what BSR is and what role the patient,

family or significant others will play.

BSR Worksheet

The third primary product is the BSR worksheet (see Appendix C). The

worksheet is developed based on the unit's culture and environment. The worksheet will

become a part of the patient census that will be used during report. The worksheet will

remind the nurses of what to cover during BSR. The NM may post the worksheet at the

nurses' station, in the break room, or on the portable computer work station.

<div align="center">

Secondary Products

</div>

The project team's development of secondary products consist of the

implementation and evaluation plans to guide the use of the primary products in practice.

The NM is ultimately responsible for training the units for the sake of the project.

Implementation Plan

Training FLNs in BSR (see Appendix D) emphasizes how the policy

implementation improves HCAHPS scores in nurse-patient communication and the

quality of patient care. The implementation plan (see Appendix G; Table G1) describes

the role of the pilot units and the implementers as well as start and completion dates. The

CNO will initiate the BSR email announcements of upcoming implementation two

months prior to the training start date. During this time, the project team will create and

plan for the training as well as plan for implementation and evaluation. Nurses can use

this time to address concerns, make queries, and prepare for the change. The NM may

choose a CN from each shift to assist with training .There will also be a CNL who is

considered a "champion user" available to help build a culture of change on the two pilot

units. The CNL takes the lead in motivating FLNs to "by-in" the change of BSR

practices. The TCAB concept is used to implement a smooth transition and institute

changes in the reporting technique. Implementation is intensely assessed during the first

four months of training and periodically for one year.

The NM seeks to obtain anonymous staff surveys to yield information on what the

nurses' thoughts about BSR. NM interests in particular question are imperative for the

implementation and evaluation of the project. Questions such as: Will nurses receive

sufficient information? Will nurses be punctual for the report? Project implementers

ensure FLNs to have the support they need to conduct BSR. The NM will continue to

monitor and offer feedback to FLNs to ensure BSR implementation is consistent and

becomes natural. The NM requests informal feedback from patients and families on

whether BSR is improving nurse-patient communication on each shift. The NM also asks

patients about improvements to better the quality of patient care. Formal feedback will be

sought by using an anonymous hospital surveys which is already in place at the practicum

hospital. The anonymous hospital surveys will consist of patient quality care surveys and HCAHPS surveys after the patient has been discharge. The NM makes round on FLNs to develop a tracking tool for progress.

Lewin's change model, SBAR, TCAB, and PDSA framework are utilized as part of the training taught by the NM. The SBAR technique (Table F1) is a secondary product used between nurses in the presence of the patient and family. The SBAR will be implemented along with the worksheet as a systematic approach to defer impertinent information during report (Reinbeck & Fitzsimons2013). SBAR framework is easy to remember, facilitates a way to relay important information, and fosters a patient safety culture. Oncoming FLNs are able to visualize and communicate with patients at the beginning of the shift which leads to optimizing patient satisfaction. Making rounds within the first 30 minutes of the shift allows the FLN to assess lines, drains, wounds, dressing, room environment, equipment condition, and availability (Reinbeck & Fitzsimons, 2013). The visualization will prompt queries based on the patient's situation. Researchers have concluded that BSR reduced the amounts of falls during the shift change and a significantly decrease medicine errors (Athwal et al., 2009; Sand-Jecklin & Sherman, 2013).

Evaluation Plan

The evaluation plan is a secondary product used to measure whether the project is successful (see Appendix H). Evaluation plans are crucial if FLNs are expected to replicate the project. The BSR project evaluation plan will present HCAHPS scores in nurse-patient communication from the previous year to identify a baseline. HCAHPS

scores for the two pilot units will be observed, tracked and recorded for twelve months. The tracking will allude whether the goal was met to optimize patient satisfaction. The data will be evaluated by comparing scores from the previous year to measure an increase in HCAPHS nurse-patient communication. The two pilot units at the practicum hospital are used to demonstrate how BSR increases HCAHPS scores in nurse-patient communication. Lewin's change model, TCAB, SBAR, and PDSA will be used as guides for the changes needed in nurses' attitudes concerning bedside handoff (Caruso, 2007; Chaboyer et al., 2009). The project team will meet on a quarterly basis to review HCAHPS scores as they are made available to the hospital. Recommendations resulting from the BSR project for individuals, communities, institutions, and systems as it relate to the BSR policy, practice, research, and social change will be supportive of the goal and outcome.

The project team will compare HCAHPS scores from last year to analyze and determine if nurse-patient communication scores improved. According to Sturder et al. (2010) the HCAHPS survey measures the patients' perception of their care during the hospitalist experience. Therefore, the project team will look for a 20% increase in HCAHPS nurse-patient communication scores over last year's metrics. The 20% change increase in nurse-patient communication will measure patients' perspective of their hospital care and indicate that the BSR project was successful. The project team will analyze the patient's response based on answering "never," "sometimes," "usually," or "always" to the survey questions (Sturder et al., 2010). A 20 % increase in scores will

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show FLN nurses who implement BSR with patient engagement will encourage more patients to give "always" responses.

Implementers will ensure FLNs have the support they need to conduct BSR, observe BSR and offer feedback to FLNs and the patient-family. Continue to monitor and offer feedback using Lewin's change model to evaluate if the change has become a natural. The PDSA tool will be used to connect performance improvements with defining, tracking and evaluating change.

Request informal feedback from patients, families, and nurses on whether BSR improved nurse-patient communication. Formal feedback can be sought by using the anonymous evaluation system that is in place at the practicum hospital. The goal and outcome that the BSR project sought to meet will optimize patient satisfaction measured by the 20% t increase in HCAHPS nurse-patient communication scores.

Analysis of Self

The BSR topic was a challenge. However, I researched it thoroughly enough to present an interesting argument. Results from my computer-assisted search to identify relevant published BSR articles were overwhelming. As a result of researching articles for my project, I cogitated about researching other nursing problems in the clinical setting with negative effects on HCAHPS score results. The DNP program at Walden University has propelled me to become a catalyst for change. This section of my paper will discuss an analysis of the project's contribution to my role as a practitioner, scholar, and project manager. I will draw a connection between the project experience, my present state, and long-term goals.

Analysis of Self as a Practitioner

As a future candidate for a Doctorate of Nursing Practice (DNP), the DNP program at Walden University has prepared me with the knowledge needed in the role of advance practitioner. My specialty in leadership requires both advance knowledge and expertise that includes regulatory and legal issues (Terry, 2012). As a practitioner, the project is honing my leadership, organizational, and economic skills as it relates to CMS reimbursement (Chism, 2009 as cited in Zaccagnini &White, 2011). I will keep abreast of changes that occur at the systemic level and continue to investigate quality improvements initiatives (Terry, 2012). According to Zaccagnini and White (2011) essential for practice two: System Thinking, Healthcare Organizations, and the Advanced Practice Nurse Leader calls for re-conceptualizing the health professional's education.

Analysis of Self as a Scholar

According to Senge (1990) a lifetime can be spent on mastering and practicing a discipline (as cited in Zaccagnini and White, 2011). I am a lifelong learner, who is also an educator and willing to learn. Moreover, learning was embedded from childhood as I was commanded to stay in school and do not drop out. I am appreciative of the scholastic cycle that I am in and excited to share educational impartations with others. The entire project was an experience for professional growth and empowerment that enabled me to engage in new and different learning practices. As a nurse, I have learning encounters that come with my yearly nursing competencies. I am committed to professional growth through continuing education units, obtaining advanced degrees, and staying abreast in current nursing standards.

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Analysis of Self as a Project Manager

The project was in response to TJC's recommendation to standardize report handoff and engage patient participation during shift report. The BSR project research helped me to understand how BSR will support nurse practice by improving the quality of healthcare. As a result of improving the quality of care, more patients will be satisfied with their care and nurse-patient communication will be better. The development of the BSR project is the first time that I researched a nursing problem, therefore; this was a challenge for me. Creating a project and planning the implementation and evaluation is more difficult than I imagined. I developed the BSR project as a quality improvement initiative to increase patient satisfaction at the practicum hospital. I saw BSR transformed into a mini version of a treatment team meeting.

Summary

The DNP program at Walden University has prepared me with the knowledge needed in the role of advanced practitioner. My specialty in leadership requires both advanced knowledge and expertise that includes regulatory and legal issues. I am a life-long learner, who is also an educator and willing to learn. I developed the BSR project for a quality improvement initiative to increase patient satisfaction at the practicum hospital. It is important financially that patients and families are satisfied with their hospital experience so insurance companies including Medicare and Medicaid will reimburse hospitals for their quality services. When patient's surveys show low patient satisfaction scores this affects the hospital's budget that also include jobs. Prayerfully I will become

a nurse educator with a DNP whose long term goal is to teach nursing in a virtual-cyber

classroom. The online class room environment has made a difference in my life.

References

Agency for Healthcare Research and Quality. (n.d.). *Nurse bedside shift report implementation handbook.* Retrieved from http://www.ahrq.gov/professionals/ systems/hospital/engagingfamilies/strategy3/Strat3_Implement_Hndbook_508.pdf

Agency for Healthcare Research and Quality. (2013). Plan-do-study-act (PDSA) cycle. Retrieved from https://innovations.ahrq.gov/qualitytools/plan-do-study-act-pdsa-cycle

American Nurses Association. (2008). *Nursing informatics: Scope and standards of practice.* ANA: Silver Spring, MD.

Anderson, C., & Mangino, R. (2006). Nurse shift report: who says you can't talk in front of the patient? *Nursing Administration Quarterly*, *30*(2), 112-122.

Athwal, P., Fields W., & Wagnell, E. (2009). Standardization of change-of-shift report. *Journal of Nursing Care Quality, 24*(2):143–7.

Baker, S. J. (2010). Bedside shift report improves patient safety and nurse accountability. *Journal of Emergency Nursing: JEN: Official publication of the emergency department nurses association*, *36*(4), 355-358. doi:10.1016/j.jen.2010.03.009

Baptist Health System [BHS]. (2014). *Patient care quality measures.* Retrieved from http://baptisthealthalabama.org/Why-Choose-Baptist/Quality-and-Patient-Safety/Patient-Care-Quality-Measure

Bleustein, C., Rothschild, D. B., Valen, A., Valaitis, E., Schweitzer, L., & Jones, R. (2014). Wait Times, Patient Satisfaction Scores, and the Perception of Care. *American Journal of Managed Care, 20*(5), 393-400

55

Burke, W., & McLaughlin, D. (2013). Partnering for Change. *American Journal of Nursing*, *113*(2), 47-51. doi:10.1097/01.NAJ.0000426690.73460.d7

Cairns, L. L., Dudjak, L. A., Hoffman, R. L., & Lorenz, H. L. (2013). Utilizing Bedside Shift Report to Improve the Effectiveness of Shift Handoff. *Journal of Nursing Administration*, *43*(3), 160-165. doi:10.1097/NNA.0b013e318283dc02

Caruso, E. M. (2007). The evolution of nurse-to-nurse bedside report on a medical-surgical cardiology unit. *MedSurg Nursing, 16*(1). Retrieved from https://www.amsn.org/professional-development/periodicals/medsurg-nursing-journal

Centers for Medicare & Medicaid Services (CMS). (2013). *Hospital value-based purchasing program*. Retrieved from http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/

Centers for Medicare & Medicaid Services [CMS]. (n.d.). Retrieved from http://www.medicare.gov/hospitalcompare/profile.html#profTab=1&vwgrph=1&ID=010016&state=AL&lat=0&lng=0&name=SHELBY%20BAPTIST%20MEDICAL%20CENTER&Distn=0.0

Centers for Medicare & Medicaid Services. (2013). *HCAHPS fact sheet.* Retrieved from www.hcahpsonline.org/Facts.aspx

Centers for Medicare & Medicaid Services [CMS] (2014). Retrieved from http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-

Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-

Value-Based-Purchasing/

Chaboyer, W., McMurray, A., Johnson, J., Hardy, L., Wallis, M., & Chu, F. Y. (2009).

Bedside handover: Quality improvement strategy to "transform care at the

bedside." *Journal of Nursing Care Quality, 24*(2), 136-142.

Chapman, K. (2009). Improving communication among nurses, patients, and physicians.

AJN, *American Journal of Nursing: 109*(11), 21-25.

doi:10.1097/01.NAJ.0000362013.53342.17

Cohen, S. (2006). Best of the basics. Change agents bolster new practices in the

workplace. *Nursing Management*, *37*(6), 16-17.

Cornell, P., Townsend, G. M., Yates, L., & Vardaman, J. M. (2014). Impact of SBAR on

Nurse Shift Reports and Staff Rounding. *MEDSURG Nursing*, *23*(5), 334-342.

Educational Portal. (2014). *Lewin's 3-stage model of change: Unfreezing, changing &

refreezing.* Retrieved from http://education-portal.com/academy/lesson/lewins-3-

stage-model-of-change-unfreezing-changing-refreezing.html#lesson

Federwisch, A. (2007). Bedside shift report ensures quality handoff. *Nurse.Com*.

Retrieved from http://news.nurse.com/apps/pbcs.dll/article?AID=

2007710080354#.VMF_fU7nag

Gosdin, C. H., & Vaughn, L. (2012). Perceptions of physician bedside handoff with nurse

and family involvement. *Hospital Pediatrics*, *2*(1), 34-38.

Graham, K. L., Marcantonio, E. R., Huang, G. C., Yang, J., Davis, R. B., & Smith, C. C.

(2013). Effect of a systems intervention on the quality and safety of patient

handoffs in an internal medicine residency program. *Journal of General Internal Medicine*, *28*(8), (986-993). doi:10.1007/s11606-013-2391-7

Grant, B., & Colello, S. (2010). Culture change through patient engagement. *Nursing*, *40*(10), 50-52. doi:10.1097/01.NURSE.0000388520.46890.1d

Gregory, S., Tan, D., Tilrico, M., Edwardson, N., & Gamm, L. (2014). Bedside shift reports: what does the evidence say? *The Journal of Nursing Administration*, *44*(10), 541-545. doi:10.1097/NNA.0000000000000115

Hodges, B. C., & Videto, D. M. (2011). *Assessment and planning in health programs*. Sudbury, MA: Jones & Bartlett.

Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS). (2012). Retrieved from http://www.hcahpsonline.org/files/HCAHPS%20Fact%20 Sheet%20May%202012.pdf

Jeffs, L., Acott, A., Simpson, E., Campbell, H., Irwin, T., Lo, J., & ... Cardoso, R. (2013). The value of bedside shift reporting enhancing nurse surveillance, accountability, and patient safety. *Journal of Nursing Care Quality*, *28*(3), 226-232. Retrieved from doi:10.1097/NCQ.0b013e3182852f46

The Joint Commission. (2007). *Improving America's hospitals: The joint commission's annual report on quality and safety: Sentinel event root cause and trend data*. Retrieved from http://www.jointcommission.org/assets/1/6/2007_Annual_ Report.pdf

The Joint Commission. (2008). Improving America's Hospitals: The Joint Commission's

Annual Report on Quality and Safety. Retrieved from

http://www.jointcommission.org/assets/1/6/2008_Annual_Report.pdf

The Joint Commission. (2010). *Advancing Effective Communication, Cultural*

Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals.

Retrieved from http://www.jointcommission.org/assets/1/6/aroadmapforhospitals

finalversion727.pdf

The Joint Commission. (2014). Facts about the National Patient Safety Goals. Retrieved

from http://www.jointcommission.org/facts_about_the_national_patient_

safety_goals/

The Joint Commission. (2015). Facts about the National Patient Safety Goals. Retrieved

from http://www.jointcommission.org/facts_about_the_national_patient_

safety_goals/

Kelly, M. (2005). Change from an office-based to a walk-around handover system.

Nursing Times, 101(10), 34-35.

Laws, D., & Amato, S. (2010). Incorporating bedside reporting into change-of-shift

report. *Rehabilitation Nursing*, *35*(2), 70-74. Retrieved from

http://search.proquest.com/docview/218310999?accountid=14872

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

43(12), 32-37. doi:10.1097/01.NUMA.0000422891.99334.68

Luther, V., Hammersley, D., & Chekairi, A. (2014). Improving patient handover between

teams using a business improvement model: PDSA cycle. *British Journal of*

Hospital Medicine (London, England: 2005), *75*(1), 44-47.

Manias, E., & Street, A. (2000). Legitimation of nurses' knowledge through policies and

protocols in clinical practice. *Journal of Advanced Nursing*, *32*(6), 1467-1475.

doi:10.1046/j.1365-2648.2000.01615

Medicare Hospital Compare Data (2014.). *Survey of patient's experience.* Retrieved from

http://www.medicare.gov/hospitalcompare/Data/overview.html

Olson-Sitki, K., Weitzel, T., & Glisson, D. (2013). Freezing the process: Implementing

bedside report. *Nursing Management*, *44*(7), 25-28.

doi:10.1097/01.NUMA.0000431431.39008.af

O'Sullivan, A., Carter, M., Marion, L., Pohl, J., & Werner, K. (2005). Moving forward

together: the practice doctorate in nursing. *Online Journal of Issues in Nursing*,

10(3), 5.

Parsons, M. L., & Cornett, P. A. (2011). Leading Change for Sustainability. *Nurse*

leader, *9*(4), 36-40. doi:10.1016/j.mnl.2011.05.005

Patterson, E. S., & Wears, R. L. (2010). Patient handoffs: Standardized and reliable

measurement tools remain elusive. *TJC Journal on Quality and Patient Safety*

36(2). Retrieved from http://www.handover.eu/upload/library/

gv2g0z55seiol04iqcvai.pdf

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

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

        doi:10.1097/NUR.0b013e3182777011

Reinbeck, D. M., & Fitzsimons, V. (2013). Improving the patient experience through

        bedside shift report. *Nursing Management*, *44*(2), 16-17.

        doi:10.1097/01.NUMA.0000426141.68409.00

Rhoades, E. A. (2011). Commentary: Literature Reviews. *Volta Review*, *111*(1), 61-71.

Riesenberg, L., Leisch, J., & Cunningham (2010). Nursing handoff: A systematic review

        of the literature, *American Journal of Nursing 110*(4), 24-34. Retrieved from

        http://www.nursingcenter.com/lnc/CEArticle?an=00000446-201004000-

        00026&Journal_ID=54030&Issue_ID=996031#sthash.IJrqGPRv.dpuf

Schroeder, S. D. (2013). Hospital value-based purchasing: South Dakota Medicine. *The*

        Journal of the South Dakota State Medical Association, 66(7), 290.

Shoemaker, P. (2011). What valuated purchasing means to your hospital? *Healthcare*

        Finance Management, 65(8), 60-68. Retrieved from

        http://www.hfma.org/Templates/Magazine.aspx?id=12598

Singleton, P. (2005).The informed patient study: the way forward for Europe

        [PowerPoint, University of Cambridge Website]. Retrieved from

        http://ec.europa.eu/consumers/archive/cons_org/assembly/8assembly2005/sp8_sin

        gleton_en.pdf

Starck, P. (1996). Boyer's multidimensional nature of scholarship: A new framework for

        schools of nursing. *Journal of Professional Nursing*, *12*(5), 268-276.

Studer, Q., Robinson, B. C., Cook, K. (2010). *The HCAHPS handbook: Hardwire your hospital for pay-for-performance success*. Gulf Breeze, FL: Fire Starter.

Szablowski, K. M. (2014). Hospital value-based purchasing (VBP) program: measurement of quality and enforcement of quality improvement. Connecticut Medicine, *78*(1), 49-51.

Terry, A. (2012.). Clinical research for the doctor of nursing practice. Sudbury, MA: Jones & Bartlett.

Vines, M. M., Dupler, A., Van Son, C., & Guido, G. (2014). Improving client and nurse satisfaction through the utilization of bedside report. *Journal for Nurses in Professional Development*, *30*(4), 166-173. doi:10.1097/NND0000000000000057

Zaccagnini, M. E., & White, K. W. (2011). *The doctor of nursing practice essential: A new model for advanced practice nursing.* Subury, MA: Jones & Barlett.

Appendices

Appendix A: Policy and Guidelines for Bedside Shift Report

Purpose: Provide guidelines for consistent Bedside Shift Report to ensure and maintain high scores in HCAHPS' nurse-patient communication; delivery of high quality patient care; and a standardize shift report.

Persons Affected: This policy is applicable to all RNs who are involved with inpatient care.

All RNs will perform end of shift communication at the patient's bedside with patient and family engagement.

- Guidelines

- Give patients-families a copy of the BSR brochure on admission and explain what BSR entails.

- Complete Bedside Shift Report work sheet.

- Introduce patient-family to on-coming RN.

- Obtain permission from patient before giving report when visitors are present.

- Encourage patient/family engagement in Bedside Shift Report.

- Discussed sensitive issues outside patient's room such as a new diagnosis not yet discussed with patient by MD.

- Report includes but is not limited to the patient's plan of care, diagnosis, reason for current admission, diet, pain status, code status, patient's history, allergies, all lines, drains, wounds, and dressing.

- Assess room environment, equipment condition and availability.

- Update white board to include at least one patient-centered goal per shift where applicable.

- Please use nursing judgment for special consideration.

- For patients on isolation nurse must wear personal protective equipment.

- Make exceptions for sleeping patients, confused, agitated, or end of life patients.

Definition

Bedside Shift Report (BSR) - Communication of important patient information between RNs at the end of shift; includes patient-family engagement.

Bedside Shift Report Brochure-Written information to helps explain the importance of BSR and what it entails.

Appendix B: Bedside Shift Report Brochure

At the change of each shift, the nurse that cared for you during the shift will introduce you to the nurse for the next shift. _____ Hospital nurses offer Bedside Shift Report (BSR) to our patients and families to help communicate important medical information and keep you better informed of your condition. BSR is a process where an off-going nurse gives report on the patient cared for to the oncoming nurse. The report will take place at the end of each shift at the patient's bedside rather that in an office. During BSR, both nurses engage the patient and their families' in the participation of the reporting process. The report helps to keep the patient informed about diagnostic tests, medications, progress, and the overall plan of care during their hospital experience. In the event that visitors are present at the time of BSR, your nurse will ask you who can participate. If you feel uncomfortable about information being discussed just make your nurse aware. Once partakers are defined, the off-going nurse will reach out to the patient and family with an invitation to participate in BSR. Verbal reports will be done outside of room if you are asleep and did not request to be awaken. BSR will benefit you and allow the nurses to continue to deliver the high quality patient care that you expect and deserve from_____ Hospital.

Appendix C: Work Sheet for BSR

Room_____Name_____

Admit
Date_____Age_____M/F_____Diagnosis_____

CPR_____ DNR_____

Doctor_____

Doctor_____

Medical
History_____

_____

Psychiatric
History _____

VS_____ Labs_____

New Orders_____

Patient Teaching_____

S_____

B_____

A_____

R_____

Appendix D: Development Plans for Training FLNs in BSR Implementation

This is a secondary plan that will guide the use of the primary products in practice. The training's main message is to emphasize how bedside shift report can improve HCAHPS scores in nurse-patient communication while improving the quality of patient care. Weeks before the training starts, the CEO will send emails to all clinical staff and doctors regarding the new policy. In addition, the policy will be posted on the hospital's policy and procedure website with training dates and times.

The NM is ultimately responsible for training the unit's FLNs for the sake of the project. However, the manager may appoint a charge nurse who can model BSR behaviors and is respected by their colleagues to assist in the training classes.

Training Objectives

NM trainer will:

Discuss the BSR policy to FLNs guided by Lewin's change model.

Discuss importance of BSR to FLN guided by plan-do-study-act model.

Discuss the BSR situation, background, assessment, and recommendation tool.

Describe BSR critical elements guided by the transforming care at the bedside model.

Appendix E: Conduct BSR Training

Upon entering the patient's room, the off-going nurse introduces the on-coming nurse to the patient and family. When visitors are present always ask the patient who can participate in BSR (the patient's preference on who participates was discussed during the admission intake). Once partakers are defined, the off-going nurse reaches out to the patient and family with an invitation to participate in BSR. Have electronic work station available along with BSR work sheet during report. The off-going nurse will engage a verbal SBAR report with the patient and family using layman's terms. The on-coming nurse conducts a quick focus assessment of the patient and a safety assessment of the room. A review of tasks that needs to be done is reported to the on-coming FLN. Discuss sensitive issues outside patient's room such as a new diagnosis not yet discussed by MD (HIV, family issues, etc.). Identify needs and concerns of the patient and family.

An individualized unit specific BSR check off sheet is used to help train and remind nurses of the critical elements required to complete BSR. Each unit must be individualized according to the unit's culture and clinical specific needs. Report includes but is not limited to the patient's plan of care, diagnosis, reason for current admission, diet, pain status, code status, patient's history, allergies, all lines, drains, wounds, and dressings. Assess room environment, equipment condition, and availability. Update the white board and include at least one patient-centered goal per shift where applicable. Use nursing judgment or special consideration with patients.

Post Training Objectives

After two days of training FLNs on the pilot units, the NM will:

- Intensely monitor implementation in the clinical setting for the first two weeks after start date, then periodically for the next four months to ensure consistency among the staff.

- Observe FLNs' shift report and provide feedback to individual nurses as needed.

- Provide continual monitoring and feedback for 12 months to ensure new behaviors are frozen and have become natural.

Appendix F: SBAR Framework for Bedside Shift Report

Table F1

	Nurse Comments
S	Off-going nurse: *"My shift is over, nurse _____ will be your nurse for the next shift. I am leaving you with and experienced nurse who will take good care of you"*. Off-going nurse: *"I am going to give report to nurse_____. Listen so that you can give feedback or ask question when I finish"*. The off-going FLN will report the patient's name, age, admitting doctor, diagnosis, and code status.
B	Off-going FLN will briefly describe patient's history related to present hospitalization, and the patient's medical, and psychological history. Report pertinent labs and tests results completed or upcoming, current treatments, meds, dressings, drains, tubes, oxygen, pulse oximetry, IV sites PICC, Ports, VS, pain rate, pain medication, and last dose. Report PCA/epidurals, precautions, isolations, fall risk, dialysis, fluid restrictions, consults for physicians, social worker, case manager, RT, PT, OT, nutrition services wound care, etc.
A	Off-going FLN will assess and report a brief review of systems and tubes, lines, and drains; and active orders. Assess patient's pain level and bath room needs and any other concerns that the nurse can address. Be specific with on-coming FLN about the assessment of patient's needs and what is going on with them now. Allow time for patient-family to ask questions.
R	Recommend the off-going FLN to review medical and nursing plan of care, new orders, and suggest that certain patient needs are executed during the upcoming shift. Report any psychosocial or educational issues involving the patient or family unit, consents forms that may need signing, pre-op checklists, and treatments. Assure the patient that they are in good hands. Thank the patient for allowing the nurse to care for them.

Appendix G: BSR Implementation Plan

The email announcement of BSR implementation will be initiated by the CNO. The announcement for classes will occur two months prior to training start date. During this time the NM will create and plan for the training as well as the evaluation of the program. Nurses can also use this time to address concerns, make queries, and prepare for the change. Classes will be taught for 16 weeks. The NM may choose a CN from each shift to assist help with training. There will also be a CNL who will be considered a "champion user" to help build a culture of change on the two pilot units. The CNL will motivate FLNs to "by-in" the change of BSR practices.

Training will consist of a purpose statement and the problem. AHRQ BSR handouts from the online handbook will be used. Lewin' change model, PDSA, and TCAB models will be used to implement a smooth transition and institute changes in reporting techniques. BSR role play/reenactment will be used to emulate what BSR will look and feel like.

Table G1

Implementation Plan

Pilot Units	Comments	Start/Completion Date	Implementer(s)
NM will announce to four north and four main units BSR training plan two weeks in advance via email. Classes will be taught for 16weeks.	Over a period of four months, nurses will attend BSR classes. Classes are six hours a day for two consecutive days per nurse for 16 weeks. Classes will end after the last nurse has been trained.	Start March, 2016 complete July, 2016. Sixteen weeks of training nurses on the pilot units. After the 16 weeks of training, BSR will be implemented for the next eight months in the clinical setting.	Nurse Manager (NM) Charge Nurses (CN).
Obtain input from nursing staff regarding the 16 weeks BSR in-service.	Establish the unit's culture, pros and cons.	March, 2016 -July, 2016.	NM and CN
Notify other disciplines of new reporting policy.	Medical Staff, Social Workers, Case Managers, etc.	March, 2016 -July, 2016.	NM and CN
BSR implementation barriers and challenges will be discussed.	Training will consist of handouts, power-point, BSR role play, and discussions. BSR training classes are not free from barriers. Challenges may have occurred that hindered BSR implementation.	March, 2016 -July, 2016.	NM and CN
Conduct BSR training classes.	Nurse from four north and four main units will be trained for 16 weeks. Handouts, power-point, role play, and discussion will be used for training purposes.	March, 2016 -July, 2016.	NM and Charge Nurse

(*Table continues*)

Pilot Units	Comments	Start/Completion Date	Implementer(s)
NN will recognize nurses who implement BSR in the clinical setting post in-service.	This is used for the nurses' continuous learning and motivation.	March, 2016-July, 2016.	NM
Discuss with Nursing Staff Education the possibility of including BSR in the new hire RN orientation.	12 month evaluation	August, 2016- August, 2017	CNO
Go live date for hospital wide BSR implementation will be discussed after 12 months of implementation and the evaluation completion of the pilot units.	The go live date will determine if nurses are ready to implement BSR hospital wide in the clinical setting after training has been completed.	August, 2016-August, 2017	CNO, NM and CN
Schedule for Chief Nurse Officer (CNO) and Nurse Director (ND) to round for support of BSR during the initial implementation.	To note the improvement in care quality, and listen to nurses input.	March, 2016	NM
Assess the need to improve or modify nurse assignments on the pilot units during the implementation. Ensure FLNs have the support they need to conduct BSR.	To assist with structure and organizational improvements.	Daily	NM
Receive feedback and communicate results with each training session.	To assist with structure and improvements	Each session.	NM
Post unit HCAHPS score when available.	To assist with structure, improvements.	Done quarterly	NM

(Table continues)

Pilot Units	Comments	Start/Completion Date	Implementer(s)
Email a write up in the employee newsletter.	To assist with moral.	After six months of implementation on the two units.	NM
			NM
Develop and schedule a tool to track BSR progress.	To assist with evaluation	Done daily	
Give feedback to staff on process; use coaching and counseling as needed.	To assist with evaluation	When indicated	NM

Appendix H: Evaluation

Evaluation measurements are crucial if FLNs are expected to replicate the project. The BSR project evaluation plan will present HCAHPS scores in nurse-patient communication from the previous year to identify a base line. HCAHPS scores for the two pilot units will be observed and recorded for 12 months. The data will be evaluated by comparing scores from the previous year to measure the increase in HCAPHS nurse-patient communication scores. Intensely assess implementation during the first four months of training and periodically for one year. The project team will compare HCAHPS scores from last year to analyzed and determine if nurse-patient communication scores improved. According to HCAHPS (2014) the survey measures the patients' perception of their care. Therefore, the project team will look for a 20% increase in HCAHPS nurse-patient communication scores over last year's metrics. The 20% increase change in nurse-patient communication will measure patients' perspective of their hospital care and show that the BSR project was successful. The project team will analyze the patient's response based on answering "never," "sometimes," "usually," or "always" to the HCAHPS survey questions. A 20% increase in scores will show FLN nurses who implements BSR with patient engagement encourages more patients to give "always" responses to the following:

1. How often did your nurses communicated well with you?

2. How often did your doctors communicated well with you?

3. How often did you receive help quickly from nurses and hospital staff?

4. How often was your pain well controlled?

5. How often did your nurses explain medicines before giving them to them you?

6. How often was your room and bathroom cleaned?

7. How often the hallway near your room was kept quiet at night?

8. Were you given information about what to do during their recovery at home?

9. How well did you understand the type of care need after your hospital discharge?

10. How would you rate the overall hospital experience?

11. Would you recommend this hospital to friends and family?

Ensure FLNs have the support they need to conduct BSR. Observe BSR and offer feedback to FLNs and the patient/family. Continue to monitor and offer feedback using Lewin's change model to evaluate if the change has become a natural. The plan-do-study-act tool will be used to connect performance improvements with "defining, tracking and evaluating" change.

Request informal feedback from patients, families, and nurses on whether BSR is improving nurse-patient communication. Formal feedback can be sought by using the evaluation system that is in place at the practicum hospital such as the anonymous hospital staff survey and the patient quality care survey (see table H).

Table H1

Evaluation Plan

Task	Evaluators	Completion date

1. Evaluate BSR after 1 year of implementation on the pilot units.
    a. Compare 2014 HCAHPS nurse-patient communication scores to 2015 scores.
    b. If there is a 20% increase in nurse-patient communication above the last HCAHPS nurse-patient communication scores then the goal is met.
    Calculate HCAPHS nurse-patient scores
	Director and Nurse Manager	March 2016

2. Refine the BSR process.	Director and Nurse Manager	March 2016