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Standardized Communication at the Bedside: A Review for Reimplementation

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Abstract

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MSN, Walden University, 2011

Associate in Applied Science, 2006

Capstone Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

This paper discusses a developmental, interdisciplinary quality improvement project that seeks to improve healthcare communication by standardizing clinician communication across all levels of care. The purpose of this project was to develop an organizational policy and interdisciplinary practice guidelines to standardize the patient handoff at the bedside. The initiative intended to use processes already in place in the organization and to integrate the knowledge from a literature review to plan the implementation of bedside handoff procedures. The quality improvement project process included assembling an interdisciplinary committee; reviewing relevant peer-reviewed literature; and developing policy, relevant guidelines, as well as long-term plans for implementation and evaluation. The literature review synthesis followed the practices suggested by Thomas and Harden. Key words were identified and coded by theme. The themes reflected patient satisfaction domains as related to communication. The headers for the literature synthesis matrix reflected the areas of communication most likely to be affected by using standardized communication at the bedside. The products of the project provide the organization with a policy and guidelines to support and sustain standardized communication at the bedside for patient handoff, as well as detailed plans for implementing and evaluating the quality improve initiative as a whole. This provides a turnkey solution to a practice problem in this specific organizational context. The project contributes to social change by breaking with long-standing traditions and implementing a patient-centered interdisciplinary communication process at the bedside, creating a process by which patient satisfaction and quality of care may be increased across socioeconomic status.

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Dedication

To my sister Ana, who with just a smile, allows me to find the energy, will, and desire to keep moving forward. To my friends, thank you for continuing to support my endeavor to attain a terminal degree in nursing. To my nursing colleagues, thank you for pushing me forward and your encouragement.

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Section 1**:** Overview of the Evidence-Based Project

Introduction

To improve interdisciplinary communication during patient handoff, in July 2011, a 229-bed acute care center implemented a hospital-wide bedside handoff approach called I PASS the BATON (IPB), Agency for Healthcare Research and Quality [AHRQ], n. d.). The acronym, I PASS the BATON, stands for introduction, patient name, assessment, situation, safety, background, actions, timing, ownership, next. It is a tool in the TeamSTEPPS program that improves communication, interdisciplinary team building, and patient safety by developing a standardized method of communication (AHRQ, n. d.). The impetus for adopting this approach came out of a brain-storming session during an interdisciplinary shared governance council's meeting which sought to improve the quality of communication among all healthcare clinicians. The council addressed the fact that many departments in the organization used different handoff forms and lacked consistency in transferring a patient from one provider to another.

The council members wanted to reduce the risk of losing important patient care information during handoff and to create a consistent system for sharing patient information among the various hospital departments (AHRQ, 2012). Although TeamSTEPPS was introduced to the organization in 2009, the organization did not have a process in place to identify IPB as the tool to be used for patient handoff. The council decided to create a policy and write guidelines to ensure that IPB was the communication tool used for patient handoff.

In December of 2012, the hospital moved into a new tower and departments were restructured. The new tower decentralized the nursing staff by not providing a hub in which all of the nurse staff and visiting healthcare clinicians could gather. However, the new layout provided nooks with medication dispensers and a computer in every room. The floor design was conducive to bedside handoff because the computer was at the bedside and allowed nurses to review patient orders, laboratory values, and visiting clinicians' orders in real time. For those times in which patient status, family dynamic, or other sensitive information was being shared, the computer work stations outside of the room provided a private location for nurses to share sensitive information. Nurses needed to adjust to this new layout, the different room setup, and the new equipment. During this transition, the bedside handoff system previously implemented with IPB did not continue. This project did not explore why the practice of bedside handoff did not continue. I believed that new guidelines were needed to reinstate bedside report practices (Olson-Sitki, Weitzel, Glisson, 2013).

Communication at the Bedside

Bedside handoff using IPB or another form of standardized communication will improve healthcare provider and patient communication (Benson, Rippin-Sisler, Jabusch, & Keast, 2006; Riesenberg, Leitzsch, & Cunningham, 2010; Olson- Sitki et al., 2013). After moving to the new tower, nurses and other clinicians can view the patient, the condition of the patient, and the environment during patient handoff. In turn, the patient can listen, participate in the plan of care, and provide feedback on the care received. The sharing of information or data occurs during patient handoff. Clinician communication

follows a standardized format that assures an organized method of exchanging patient care data (Cairns, Dudjak, Hoffman, & Lorenz, 2013).

Patient data gained from applying the nursing process to care must be communicated to other healthcare team members and charted in the patient's medical record. Standardized communication between healthcare clinicians using IPB becomes more important during patient handoff from one level of care to another (Caruso, 2007). The terms *patient handoff, patient transfer, bedside shift report, beside handoff, transition of care* (Joint Commission Center for Transforming Healthcare, 2014), and *patient transfer of accountability*, are used interchangeably in the literature in discussing standardized communication during patient handoff.

Effective Communication and Patient Satisfaction

Sherman, Sand-Jecklin, and Johnson (2013) suggested that using a form of standardized communication, such as IPB, combined with bedside handoff increase patient satisfaction scores. The patient satisfaction scores are reportable outcomes in the form of questions created by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS, 2012). The survey includes several questions as they relate to communication between healthcare providers and patients that are found within the HCAHPS Patient Satisfaction Domains and two items specific to overall patient satisfaction. Positive patient satisfaction scores, and sustaining increased patient satisfaction values directly influence a hospital's financial status and survivability (Healthcare Financial Management, 2012; Cairns et al., 2013; Studer, 2014).

The Centers for Medicare and Medicaid Services (CMS, 2013) uses the term *domain* to describe the different processes of the patient experience of care. These processes are measurable actions or interventions; they are reported to CMS as part of the Value-Based Purchasing program (CMS, 2013). While none of the patient experience domains were identified in the needs assessment or planning stages of implementing IPB, the literature review identifies positive patient satisfaction outcomes (AHRQ, 2012; AHRQ, 2013; Chin, Warren, Komman, & Cameron 2011; Sherman et al., 2013; Manning, 2006; Scovell, 2010; Grimshaw, Hatch, Willard, & Abraham, 2016; Bruton, Norton, Smyth, Ward, & Day, 2016; Taylor, 2015). Data from the hospitalcompare.gov website can be used to support the policies, guidelines, and curriculum created to re-implement bedside handoff within the organization. The decision to use this publicly available data was left up to the interdisciplinary committee. The planning committee and I decided that any data collection would occur after implementation and at the executive leadership's discretion. A decision was made that data would not be collected and reviewed during the DNP project. The project would be evaluated after the hospital reimplemented the products of the DNP project. Evaluation of the DNP product was not expected until at least 6 months after project deployment.

Plans for re-implementation of bedside handoff using standardized communication included a policy and guidelines that incorporated current handoff practices. I ensured that there was a plan within the committee charter that set a date for future analysis of patient satisfaction scores. The domains to be evaluated a year after implementation include nurse communication during the patient's hospital stay;

physician communication during the patient's hospital stay; a patient's likelihood of recommending the hospital; and the overall rating of the hospital. A review of the patient satisfaction scores as they relate to communication with his or her care providers will occur within a 6-month period after implementation. The top-level executives at the hospital have direct access to the patient satisfaction scores and the planning committee received a commitment to be able to access the data and after project implementation.

The council decided that bedside handoff using IPB, would fit the organization's patient-centered vision and mission of the hospital (Baker, 2010; Griffin, 2010; Tan. 2015). The patient-centered communication tools and patient care philosophy in place within the organization are defined in the Definitions of Terms section.

Problem Statement

The problem I addressed was poor communication between healthcare professionals, as identified by the professional practice shared governance council. The hospital had processes and tools in place to support communication during patient handoff, but lacked organizational policies and procedures to identify which tools and methods of communication were to be used. The lack of consistency and the lack of a specified, standardized tool for transfer of patient information created interdisciplinary communication issues. For example, some units used the Situation, Background, Assessment, and Recommendation (SBAR) format, while other units used a tool created just for that unit. During this time, all employees were being trained to use IPB, but they were not instructed to use IPB during patient handoff. In addition, patient handoff

occurred away from the patient. This practice was not aligned with the organization's patient-centered mission and vision and warranted a guideline for standardization

The lack of consistency in communication lowers patient satisfaction scores and clinical care outcomes (AHRQ, 2013; Wolosin, Ayala, & Fulton, 2012). The interdisciplinary shared governance council identified that patient care communication needed to improve, and that the organization needed to specify one standardized method. The council decided to review the programs and practices in place; it selected IPB as the standard. The change in the method of communication was expected to increase the quality of communication between the healthcare teams The council also expected the new method to improve patient care outcomes (Scovell, 2010; Thomas & Donohue-Porter, 2012). The plan for standardized communication during bedside handoff aligned with the organization's quality improvement goals and patient-centered vision (Anderson & Mangino, 2006; Baker, Sherman et al., 2013; Midland Memorial Hospital, 2009).

Increasing patient satisfaction scores was important because of value based purchasing (VBP) because it is related to hospital reimbursement. Hospitals must have quality improvement programs in place to address and improve each component of VBP and HCAHPS in order to continue receiving Medicare reimbursement. The implementation of IPB was intended to improve the quality of communication in patient handoff. The committee would use the results of the literature review to support re-implementation of a IPB to standardize communication at the bedside that fits the mission and vision of the hospital, and to increase HCAHPS scores for communication.

I decided to apply the problem, intervention comparison, and anticipated outcome model to the quality improvement project. This model would allow the introduction of evidence-based practices to change how we handoff patients within the hospital. PICO assists in creating a practice question or questions that must be address to change clinical practice (White & Dudley-Brown, 2012). As a model to improve interdisciplinary collaboration, PICO will also guide the literature review search. The PICO problem statement was as follows:

P- Poor communication between clinicians and low overall patient satisfaction

I- Bedside report using I PASS the BATON

C- No bedside report

O- Improved communication as reflected by increased HCAHPS scores

Purpose Statement

The purpose of the project was to develop organizational policy and interdisciplinary practice guidelines to standardize patient handoff at the bedside using IPB. The new policy and relevant practice guidelines were intended to be implemented through the hospital's professional practice shared governance council. Use of the shared accountability council would ensure interdisciplinary collaboration in planning, developing, and implementing a hospital-wide initiative similar to the one in 2011.

Goals and Outcomes

The goal of the project was to improve interdisciplinary health care provider communication and overall patient satisfaction in the organization. A committee of interdisciplinary stakeholders, from the same shared accountability council, discussed,

planned and agreed upon expected outcomes. The team deliverables included creating a new set of guidelines, and recruiting stakeholders for this project within the hospital's administration. Finally, if approved by nursing administration, a small patient information card would be created to inform the patient of what to expect during his or her transfer of care or patient handoff (AHRQ, 2013). The outcome by which the project goals would be measured was an increase in patient satisfaction based on predetermined patient input criteria as designated by the organizational leaders. Another outcome would be increased patient safety. The standardizing of communication and bedside handoff would require a behavior based change theory and rationales based on increasing patient safety.

Theoretical Foundation

In 2010, the National Patient Safety Foundation (NPSF) reviewed the Institute of Medicine's report *To Err is Human,* with a focus on listening to patients and families (Balik, 2010; Cairns et al., 2013). Issues identified within the report pertained to existing systems and processes to improve patient care. According to Balik (2010), there is not one solution, system, or process to improving patient care. The healthcare team must include the patient in the conversations involving his or her care. Ten years after the IOM report, the NPSF found that communication problems continued to be identified as a systems issue. Communication problems must be addressed by healthcare organizations (Clancy, 2009), and must have an all-around interdisciplinary approach.

Clear and open communication is essential to preventing adverse events and patient harm (Thomspon – Moore & Liebl (2012) because communication breakdown

contributes to over 70% of sentinel or never events. Over 50% of those communication breakdowns occur during handoffs. These failures in communication occur during a patient transfer, patient discharge, and medication administration. They identified specific situations where failures of communication have been consistently. These failures were presented to the members of the planning committee:

- Admission into any healthcare facility
- Patient handoff
- Patient care communication
- Medication administration and medication reconciliation
- Patient discharge from any healthcare facility

The theoretical foundation for transformation of practice is based on two books by Quint Student. The theoretical concepts in TEAMSTEPPs and IPB were applied to improve interdisciplinary communication between all healthcare clinicians. I was introduced to Studer's "Hardwiring Excellence" book during the initial rollout of the transformational leadership principles. The book entitled the "HCAPHS Handbook," in which the author suggested that bedside report using standardized communication would improve patient satisfaction scores (Studer, Robinson, & Cook, 2010; Spaulding, Gamm, & Griffith, 2010) provided the rationales for reintroducing bedside handoff. The planning committee’s literature review found evidence supporting the theory that standardized communication at the bedside improves patient satisfaction and patient safety and is discussed in section two of this paper

Studer (2003) provided the theoretical concepts already in place to create behavior-based change within the organization. The project would incorporate existing systems and processes within the organization that were being sustained through Studer's principles of leadership transformation and management. The council needed to transform the current behavior of conducting the patient handoff away from the patient and move it to conducting it at the bedside. The council also took advantage of the processes and systems already in place and combined current processes to support the change. For example, all employees were trained in TEAMSTEPPs and IPB; sticking with IPB would not create additional costs, training time, or extra labor costs (Arora, Johnson, Meltzer, & Humphrey, 2008).

Transformation of practice would be supported, sustained, and guided by hospital administration (Brooks, 2008) and project champions. Studer's transformational theories and administrative best practices were applied to the implementation of this quality improvement project. These theories consisted of management theories, principles created by Studer, and "pillars" (Spaulding et al., 2010, p. 4) or goals set by the organization as a basis for creating change and sustainability. These principles were ready to be applied to the upcoming transformation of practice.

The teambuilding theories and communication best practices found within TEAMSTEPPs and IPB allows for systematic transmission and reception of patient information in the same format for all individuals involved. Standardizing of communication between healthcare clinicians is one process that combines the different channels of communication and allows a clear message to be shared, accepted, and

understood (Manning, 2006). Communication between members of the same disciplines will vary based on clinician behaviors. Verbal and non-verbal behaviors could influence how effective and accurate was the exchange of information (Parush, Kramer, Foster-Hunt, Mcmullan, & Momtahan 2014). For example, if both clinicians use the same communication standardization tool of IPB, the mnemonic can be used to keep focused on the patient handoff even with interruptions. The same standardized format allows for an individualized report based on different patient characteristics and needs (Baker, 2010). Bedside reports put the patient in the middle of the conversations about his or her health and clinical care plan. Griffin (2010) noted that bedside handoff allowed nurses to connect individually with the patient and their families.

This connection supports the sharing of patient data, which allows the patient to participate in the planning of his or her care. It is this connection that increases patient satisfaction (Baker, 2010). Standardizing communication during bedside patient handoff fulfills the professional practice concepts of patient care, effective communication, and patient-centeredness (McMurray, Chaboyer, Wallis, & Fetherston, 2010). In addition, standardized communication closes the gap in interdisciplinary communication, improves patient engagement, reduces patient vulnerability, and increases the quality of communication between all parties involved in the care of the patient.

Significance of the Project

Typical nurse-to-nurse handoff occurs away from the patient; this is the traditional nursing practice. At times, handoff occurs via a recorded message or written report (Sherman et al., 2013). Making it occur at the bedside required a paradigm shift.

Clinician training was required as well as the development of additional skills in the care provider (McMurray et al., 2010). Bedside handoffs save lives, reduce adverse clinical occurrences, reduce patient care errors, and improve the quality of the nurse handoff report (Thomas, Schultz, Hannaford, & Runciman, 2013). Weeks and Weinstein (2014) suggested that VBP has created an impetus for healthcare organizations to create programs that directly influence hospital reimbursement from CMS.

Bedside handoff using the IPB program changes the method of patient handoff in a way that may improve patient satisfaction (Sherman et al., 2013) The quality improvement initiatives created by healthcare reform to reduce costs forces hospitals to become creative in implementing programs that seek to improve patient quality programs (Staggers & Blaz, 2013). Bedside handoff using IPB, a standardized template, or a standardized checklist that is patient-focused, may affect more than just patient satisfaction scores (Wolosin et al., 2012). It would likely improve the quality of patient care and healthcare efficiency.

Implications for Social Change

The Patient Protection and Affordable Care Act of 2010 (PPACA) created an impetus to move the patient to the center of care (CMS, 2014). This patient-centered movement has created a need to transform healthcare practices to meet the demands of healthcare reform and reimbursement guidelines. Epstein and Street (2011) noted that the PPACA has transformed the social aspects of the relationship between the healthcare provider and the patient. They saw that a patient-centered focus must be maintained by anyone who is a healthcare patient representative whether providing direct care, dealing

with financial issues, or with health related legislative decisions. Healthcare reform and CMS reimbursement guidelines will continue to create this social change in healthcare.

Using IPB during patient handoff provides a set method of communication for all parties involved. As the patient enters the hospital, she should be notified that the healthcare clinicians use a standard format to communicate patient needs, patient care plans, and patient information from one clinician to the other (AHRQ, 2013). Thus the patient becomes aware of the use IPB to standardize communication, and can follow the steps of communication about his care. The family can also follow the steps of communication (AHRQ, 2013). Although every discipline's focus is a bit different, IPB helps keep the channels of communication open (Manning, 2006) and flowing forward to complete the patient's care plan, and eventual discharge. Baker (2010) discussed that the use of IPB increases the patient's trust in her care, and creates an environment conducive to patient engagement in the plan of care.

Traditional handoff occurs away from the patient (Sherman et al., 2013; Thomas, Schultz, Hannaford, & Runciman, 2013); it excludes the patient and therefore is not patient-centered. Staggers and Blaz (2012) found that current handoff traditions are not supported by evidence-based practice. Nurses must move the patient handoff to the bedside in order to meet the social change of patient-centeredness. Such fundamental change in patient transfer philosophy and practice requires skill-building techniques (Thomas & Donohue-Porter, 2012), and the creation of organizational processes to implement (Staggers & Blaz, 2012) bedside handoff using IPB.

Assumptions and Limitations

Assumptions

This study was subject to several assumptions: (a) all interdisciplinary health care providers would use IPB at the bedside to standardize patient handoff communication; (b) bedside handoff would improve interdisciplinary communication (Petrovic et al., 2015) due to the standardization of communication. All health care providers would participate in patient handoff; and nurses would participate in handoff reports with non-nursing disciplines. An additional assumption was that the non-nursing disciplines would hand off to the nurses before and after providing care to the patient. I recognized that the Empirical Outcomes content validation tool would support the project and not create changes that would change the theoretical foundation of the project. The DNP believed that project would stand the scrutiny of the field experts with a background in physician–nurse collaboration. I assumed that the executive level champions (Brewster, Curry, Cherlin, Talbert-Slagle, Horwitz, & Bradley, 2015) would embrace this project as a quality improvement plan to improve interdisciplinary communication.

Limitations

There was no guarantee that the project would be approved as presented. There was a possibility that there might be modifications made in the communication tool. For example, some of the committee nurses might have preferred to implement a different communication tool other than IPB such as SBAR. The policy and guidelines would be reviewed by members of the executive team and there was no assurance that the policy introduced through the project would remain intact and unedited as it endured the review process. There was no assurance that all members of the subcommittee would review the

literature provided or would add additional discipline specific literature to support participation in interdisciplinary bedside handoff. The literature review did not identify any phenomenological studies about how bedside reports increased patient satisfaction. At the time of literature review, there was no example of a policy or literature that demonstrated the best method of implementation or set competencies to check off all healthcare providers at MMH in using IPB. The outcomes of potential limitations will not be determined until after evaluations are completed as DNP Project recommendations are implemented.

Summary

The interdisciplinary quality improvement project deliverables identified IPB as one form of standardized communication, moved patient handoff to the bedside, provided a plan for implementation and suggested an evaluation plan a year after deployment. The project needed champions from all healthcare disciplines within the hospital and all levels of leadership. An interdisciplinary committee would be created from members of shared accountability councils and volunteers. The committee would then conduct an interdisciplinary literature review and create a charter that would identify the key components of the project and stakeholder for sustainability. No data would be collected during the project development and implementation and the project paper would be delivered to expert in the field of organizational communication for content validation.

Hospital-wide implementation of bedside shift reporting using standardized communication such as IPB was expected to improve communication between all members of the healthcare team and the patient. Improvement in communication would

enhance patient satisfaction scores in the units that participated in the patient intervention project Most importantly, the improved communication would increase the patient's engagement in his or her plan of care (Laws & Amato, 2010). Patient engagement is believed to increase adherence to care plans (Griffin, 2010). Improvement of the above outcomes could directly contribute to improving an organization's profitability (Studer, 2013). An interdisciplinary literature review would be the first step in initiating the quality improvement project.

Section 2: Review of the Scholarly Literature

Introduction

The literature review focused on the effects of using IPB or other standardized communication methods during patient handoff. The focus was on bedside methods rather than the more common practice of transfer of information out-of-sight from the patient in question. One goal was to provide a viable baseline for discussion of factors relating to improvements in patient care through implementation of bedside transfer from one health provider to another. I focused on results that focused primarily on nurses and nursing care. While the focus was primarily on nursing care, there were a number of related subjects that ranged from broad-based regulatory changes in patient care such as content found in the Patient Protection and Affordable Care Act of 2010 to specific information concerning improvements in patient satisfaction and effective treatment through use of standardized communications procedures at the bedside. To focus entirely on literature pertaining only to nursing care would have limited access to highly applicable findings related to general patient care. I believed it was important to include interdisciplinary journals and sources to meet the vision of creating interdisciplinary practice guidelines.

Literature Search Strategy

The initial search using the coded themes included over 238 articles in nursing, psychology, and business databases. The inclusion of the business databases was related to TEAMSTEPPs' development within the business, airline, and military sectors. The AHRQ became the primary source for TEAMSTEPPs literature and strategies specific to

healthcare. Articles not mentioning the coded themes were excluded. Conference presentations, book reviews, non-peer reviewed articles were also excluded from the initial search. Anecdotal and editorial articles were screened and excluded from this literature synthesis. Duplicate articles were removed and articles found on the AHRQ website were excluded to avoid duplicating the literature from the website.

One hundred and twelve articles were reviewed and screened. Of these, fit two out of three of the patient satisfaction domains related to communication. A fourth column to the literature synthesis matrix was added because the outcomes related to patient safety kept repeating throughout these 47 articles. The key words were entered into a table and sorted by author and date published. Articles matching the coded themes were added to the literature synthesis matrix (Appendix A). The coded themes were then aligned with the patient satisfaction domains measured by the HCAHPS. Using a thematic literature synthesis allowed me and planning committee to maintain the focus of the goal of improving interdisciplinary communication and one performance improvement theme. The literature review identified several commonalities and key words associated with bedside report including standardized communication, structured interdisciplinary communication, patient-centered care, patient satisfaction with care, improved patient care outcomes, and nurse and healthcare clinician satisfaction.

The literature review used the following databases: Academic Search Complete, Business Source Complete, CINAHL Plus with Full Text, Cochrane Database of Systematic Reviews, ERIC, LegalTrac, MEDLINE with Full Text, National Bureau of Economic Research, NHS Economic Evaluation Database, ProQuest Nursing and Allied

Health Source, Sage Premier, Science Direct, Science Journals, and SocINDEX with Full Text. Searches were conducted on these keywords: *bedside report, bedside shift report, bedside handoff, bedside communication, patient accountability, standardized communication, bedside transfer, transfer of accountability, and patient transfer.* The associated themes using standardized communication were *nurse to nurse communication*, *nurse to patient communication*, *nurse to healthcare team communication*, and *bedside transfer of accountability*. The characteristics of *patient-centeredness, accountability*, and *patient safety* were included in the literature search and subsequent tools to implement bedside reporting using standardizing communication. The time frame ranged from 2003 to 2016. Articles were selected based on clinical application of bedside report using standardized communication.

I used an evidenced-based strategy to synthesize the literature found during the initial and subsequent review. Thomas and Harden (2008) discussed several methods of synthesizing literature by applying a standardized format to identify key themes in a literature search. The thematic analysis identified several key ideas that were coded after a general review of the literature. The literature review synthesis followed the suggested practices by Thomas and Harden (2008). Key words were identified and coded by theme. The themes reflected patient satisfaction domains as related to communication. The headers for the literature synthesis matrix (Appendix A) reflected the areas of communication most likely to be affected by using standardized communication at the bedside. The priority characteristics identified by the authors were then plugged into the

matrix. Key words identified in the peer-reviewed articles were also entered in to the matrix.

Specific Literature

Specific literature identified the AHRQ as a comprehensive resource along with tools that would allow an organization to improve communication and implement bedside report. The AHRQ created a guide to help acute care centers improve the quality of care through patient engagement (AHRQ, 2014; AHRQ, 2013; AHRQ, 2013b; AHRQ, 2012). The guide was separated into four strategies in order to facilitate an organizational shift towards a patient-centered care environment. Resources and tools to move traditional patient handoff to the bedside are readily available and in many cases are public domain documents available through the AHRQ (2013). The AHRQ provides all of the tools, checklists, PowerPoint presentations and resources needed to educate the nurses, patients and healthcare professionals. The acute care organization implementing bedside reports using standardized communication can apply the strategies recommended by the AHRQ. These strategies included how to successfully implement patient-centered care interventions within an organization.

Balik et al. (2011) discussed the different principles that healthcare organizations must have in place to drive patient-centered and family-centered care. These key drivers are critical in creating an environment in which the patient and family feel welcomed to participate in his or her interdisciplinary care plan. The researchers believed that a healing environment promotes patient and family engagement in the plan of care, and this engagement is what encourages a patient's trust (Herbst, Freisen, & Johnson, 2013;

Pentland, Forsyth, Maciver, Walsh, Murray, Irvine, & Sikora, 2011) in his or her care providers. Increased trust allows the patient to contribute directly to the communication about his or her care plan within the acute care setting and after discharge (Balik et al., 2011; Gregory, Tan, & Tilrico, 2014). Direct communication at the bedside with all health care team members who contribute to the patient's care at the bedside, fits this principles of patient-centered care (Gregory et al., 2014; Sand-Jecklin, 2014;Taylor, 2015; Hervst, Friesen, & Speroni, 2013; Howard & Becker, 2016).

Kassean and Jagoo (2005) pointed out that moving handoff report to the bedside breaks a long-standing tradition and improves the quality of nurse-to-nurse communication. According to Kassean and Jagoo, traditional report is one-sided, at times outdated, and incorrect. This somewhat disconnected type of communication excludes the patient, whom might be able to correct misinformation, and participate in his or her care plan. Patient handoff occurs away from the patient, and the receiving clinician is unable to see the patient during report. The traditional handoff does not meet the goals of patient-centered care (Olvera & Campbell-Bliss, 2011; Bradley & Mott, 2013; Johnson, Carta, & Throndson, 2015; San-Jecklin & Sherman, 2014) because the exclusion of the patient does not contribute to creating an environment that includes the patient in this planning of care.

The key drivers included ensuring that everyone in the organization is focused on providing patient-centered care (Balik et al. 2010). This care is delivered by a multidisciplinary staff that is influenced by an individual desire to provide patient-centered care in a healthy environment. The healthy healing environment is created by

asking, encouraging and supporting the patient to determine how they would like to participate in their care (Pentland et al., 2011; Staggers & Blaz, 2012; Bradley & Mott, 2013; Brown & Sims, 2014; Hagman, Oman, Klefner, Johnson, & Nordhagen, 2013; Gregory et al., 2014). All care delivery is provided in a nondisruptive manner and sustained through organizational policies that reflect the values of patient-centered care (Balik et al., 2011; Gregory et al., 2014). Enabling the patient to be included in informational updates as care is transferred from one healthcare provider to another is a valuable addition to providing patient centered care.

Policies are just part of the drivers needed to deliver patient-centered care. Organizational and front line leadership must also ensure that all care delivery systems and processes are aligned with the patient-centered care values (Studer, 2003; Spaulding et al., 2010; Pentland et al., 2011; Dufault, et al., 2010) to ensure that reliable care is delivered around the clock. Practice guidelines are one key driver for patient-centered care that an organization may use to apply evidence-based practices to ensure delivery of the best care possible to produce the greatest patient care outcomes (Balik et al., 2011; Studer, 2014; Grimshaw et al., 2016; Salani, 2015; Radlke, 2013).

Lack of visual inspection of the patient reduces the quality of handoff report (Timonen & Sihvonen, 2000) because the patient's status might change during report. The process of handoff at the bedside using IPB reduces patient care errors and fulfills the patient's psychosocial to be in control of his or her care or care outcomes (Chin et al., 2011; Spivey, 2014). Sherman et al., (2013) believes that it is the improved communication centered on the patient that allows nurses to identify potential errors and

push the patient care plan forward. It is the positive movement forward towards discharge that contributes to increased patient trust in his or her care (Chin et al., 2011; Ford, Heyman, & Chapman, 2014). The increased confidence in nursing care contributes to increased patient satisfaction with communication between nurses and all members of the interdisciplinary care team (Timonen & Sihvonen, 2000; Ofori-Atta, Binienda, & Chalupka, 2015: Maxson, Derby, Wrobleski, & Foss, 2012). Baker (2010) believed that a bedside report reduces a patient's anxiety, allowing the patient to become engaged in his or her care. The engagement in his or her care plan increases the patient's trust in the nurses who provide care and in other health care providers that participate in the bedside report (Vines et al., 2014; Johnson et al., 2015; Bruton, Norton, Smyth, Ward, & Day, 2016; Klim, et al., 2013, Chapman, 2016; Robbins & Dai, 2015).

Improving Interdisciplinary Communication

Manning (2006) emphasized that each health care discipline has a different focus or wavelength of thinking when caring for a patient. The healthcare clinician background and specialties contribute to patient vulnerability because each specialty operates on a different "channel" of communication or healthcare priority (p. 268). Standardizing the method of communication using IPB during bedside handoff reduces patient vulnerability, variability, and allows the patient to learn about the healthcare team members' different priorities (Sherman et al., 2013). According to McMurray (2006), standardization of communication allows the transmission of the message to reach the individual in almost any environment and enables the recipient of the message to be able to understand what is being said. Anderson and Mangino (2006) asserted that bedside

report using standardized communication increases interdisciplinary communication, supports a clinician's accountability to the patient, and improves communication.

Baker (2010) reasoned that a bedside report using standardized communication in the emergency room provides a quicker handoff, and allows the emergency room nurse to spend more time caring for patients. Laws and Amato (2010) noted that a standardized communication tool such as IPB used in handoff improves communication by providing an efficient, effective and consistent method of handoff report. Improved communication increases patient satisfaction and increases patient engagement (Benson et al., 2007; Scovell, 2010; Griffin, 2010; Thomas & Donohue-Porter, 2012; Gregory et al., 2014). Chin et al.,2011; Evans, Grunawalt, McClish, Wood, & Friese, 2012; Lupieri, Creatti, & Palese, 2016).) asserted that bedside reports allows the patient to perceive a positive view of interdisciplinary collaboration, increased patient safety, and improved quality of care.

Additional themes related to standardized communication repeated throughout the literature review were identified as *accountability*, and *patient-centeredness* (Cornell, Gervis, Yates, Vardaman, 2014; McMurray et al., 2010; AHRQ, 2013; AHRQ, n. d; Weaver, Lubomksi, Wilson, Pfoh, Martinez, & Dy, 2013). Bedside handoff contributes to increased interdisciplinary teamwork and accountability (Baker, 2010; Anderson & Mangino, 2006; Laws & Amato, 2010; Kitson, Athlin, Elliott, & Cant, 2013), interdisciplinary communication (Benson et al., 2007; Thomas & Donohue-Porter, 2012), and healthcare team satisfaction (Anderson & Mangino, 2006; Vines, Dupler, Van Sorn, & Guido, 2014; Gregory et al., 2014), and builds the patient's confidence in his or her plan of care (AHRQ, 2013). One rationale for implementing bedside reports was to

increase satisfaction with communication between physician and nurses (Manning, 2006; Kassean & Jagoo, 2005). Alvarado et al., (2006) suggested that all disciplines should be encouraged to implement bedside reports using a standard method of communication in all interactions with patients and the interdisciplinary healthcare team. This patient-centered practice contributes positive attitudes about the patient care and increases the trust that the patient develops through bedside communication. The positive perception of care and feeling of empowerment (Caruso, 2007) could positively increase patient satisfaction scores with doctors and nurses.

Standardized Communication According to TeamSTEPPS

Thomas and Donohue-Porter (2012) stated that bedside reports directly contribute to increased personal satisfaction for nurses concerning the type of patient care they provide. Also, they asserted that bedside reports are a team building process. TeamSTEPPS uses a form of standardized communication to encourage interdisciplinary care providers to address issues and concerns about patient care in an environment that is conducive to improving patient care outcomes. In addition to TeamSTEPPS, the AORN (2012) also suggested that bedside handoff using IPB should occur for break coverage and for any transfer that occurs during the patient's stay. For example, if a patient is transferred to a different department for a procedure or treatment, AORN (2012) and AHRQ (2013) both suggested that a bedside report take place to ensure a safe transfer of care. A transfer of patient accountability occurs when the patient leaves the primary nurse's care. Such transfers are one of the moments that Thompson-Moore and Liebl (2012) identified as a critical occurrence of patient vulnerability.

McMurray et al., (2010) recommended that transfers out of the acute care center to other facilities warrant a bedside handoff using a standardized method of communication. Caruso (2007) asserted that bedside report using standardized communication such as IPB increases the patient's sense of security and enhances the patient's trust in his or her nurses. Feelings of security enable the patient to become involved in his or her care plan and helps the patient feel empowered when they participate in making care decisions during bedside reports. McMurray et al., (2010) suggested that feelings of trust in care providers, engagement in the plan of care and increased sense of security increase patient satisfaction. Several of the articles speak to the transfer of responsibility as being synonymous with patient handoff (Spivey, 2014; Lane-Fall, Beidas, Pacual, Collard, Peifer, Chaves, et al., 2014; Alvarado et al., 2006; Anderson & Mangino, 2006; Bluni, 2006; Kleier, 2013; Timonen & Sihvonen, 2000).

Conceptual Model

The framework for the conceptual model was based a discussion of identifying several main ideas or themes that would provide a visual map to assist in the development of the goals of the quality improvement initiative. The visual map allowed the project leader to demonstrate how themes or ideas are related to each other, or can be combined to create a patient care intervention that may be conceptualized through research (Trochim, 2006). Another goal of concept mapping is to bring together a team's primary views of how to apply several ideas or objectives without losing individual or distinct interdisciplinary thought. The main ideas that guided the literature review, planning and discussion of this quality improvement project were patient or person-

centered care, standardized communication at the bedside, and application of TeamSTEPPS' team building concepts that include IPB.

The organization adopted the IHI's Person- and Family-Centered care model (Frampton et al., 2010) to improve the quality of patient care within the organization. The goal of the participating stakeholders and planning committee was to improve the quality of communication among all disciplines within the organization. The organization had a teambuilding program in place called TeamSTEPPS. Within the TeamSTEPPS program, a standardized method of communication was recommended and accepted throughout the organization. The principle of patient-centered care was the guiding impetus to improving interdisciplinary communication to improve patient care outcomes through standardized communication as taught by TeamSTEPPS at the bedside.

Studer's (2010) assertion that bedside report directly contributes to increased patient satisfaction fit within the concepts of improving interdisciplinary communication and collaboration. The project's institutionalization of IPB bedside communication in patient handoff fit well with this quality improvement project and would further organizational efforts to improve patient-centered care. Studer (2010) suggested that one method of standardized communication intended to aid in communicating with patients and family concerning the care to be provided. Studer suggested a standardized format similar to SBAR but did not give specifically identify a required format. His recommendation was to standardize the communication at the bedside. Studer's (Brooks et al., 2010) concepts of hardwiring excellence through "passion, principles, and pillars" (p. 2) was the theoretical foundation for this quality improvement project. Studer (2010)

suggested thanking the patient and family for participating in bedside report to increase patient engagement in his or her care.

Studer (2014) pointed out that organizations that are failing financially share "specific traits"(p. 90) that must change to improve outcomes. One of those traits is low patient satisfaction scores. Studer (2013) used the term "passion" (p. 2) for excellence as the approach to improving outcomes. This passion combined with principle-based interventions sustained by goals created by all members of an organization is what causes behavioral based changes. These behavioral changes would be needed to move the handoff to the beside and breaking with tradition. The passion, principles, and goals must be both organizational and personal. The principled based interventions, according to Studer (2003) must be supported not just by goals, but by ensuring that all members of the organization have the skills to meet the goals. These skills are supported through organizational systems, processes and technology. Bedside report using standardized communication improve patient satisfaction scores (Studer, 2010), but the change must be supported by organizational processes and employees as leaders that have a desire to transform practice. The processes or policies must be supported through leadership rounds, goal setting, technology, and outcome reporting. All organizational actions must lead towards the success and financial stability of the organization and receive the full support of the executive staff to the front line employee (Studer, 2003).

The multidisciplinary practice guidelines could be used to create an educational course that provides the background, rationale, and expected outcomes of this quality improvement project. This educational course also needed to be interdisciplinary. During

the first round of discussion in 2010, a competency or skills checklist was discussed but dismissed. The tabling of this discussion was due to the amount of time and labor to complete a skills checklist for every healthcare provider within the organization. The amount of time and labor to complete a competency for every healthcare provider was identified to be a major barrier to implementation.

Summary

The literature search focused on bedside reports using standardized communication literature review to provide a multifaceted view of how patients could benefit from bedside report implementation. It was expected that the consequences of bedside reports using standardized communication will create a positive difference in patient satisfaction after implementation. An interdisciplinary quality improvement project involving moving patient handoff to the bedside would need a policy that identifies IPB as the standardized method of communication. The policy would need to include the requirements for patient handoff at the bedside, and parameters in which the nurses and other healthcare providers might need to step away from the bedside. The intended policy needed to include references from all of the different disciplines found within the organization. Each discipline found and bring forth a reliable source how standardized communication to increase collaboration and improve communication between different healthcare disciplines. The majority of the information found was from the AHRQ. The policy needed to emphasize MMH's patient-centered care philosophy, and remind all team members that they received training in using IPB during orientation.

The existing practice guidelines needed to be revised. During several discussions there was a perception as if the guidelines were prescriptive and did not allow for adaptation in relation to the practice environment. There was a possibility that the council would not accept IPB and choose another form of standardized communication as in SBAR. I believed that moving the handoff report to the bedside was the key outcome that needed to be attained. The discussions on how to approach the councils, the CNO, and the creation of a charter occurred rather quickly. The literature synthesis matrix was an unexpected outcome. I believe that the matrix allowed for a quick review of the literature based. I was able to glance at the synthesis matrix and look up the articles by theme.

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Section 3: Approach

Introduction

The project addressed the problem of poor communication between healthcare professionals and low overall patient satisfaction scores. The goal of the project was to develop an organizational policy and interdisciplinary practice guidelines to standardize patient handoff at the bedside. A second goal of the project was to improve the communication of the interdisciplinary health care provider in the bedside handoff and subsequently to increase patient satisfaction scores with respect to communication in the organization. The members of the planning committee provided interdisciplinary collaboration in developing and implementing a hospital-wide initiative similar to the one in 2011. The main difference between the new project and the initiative in 2011 was the first initial focused on changing nursing practice alone. The new quality improvement project a focused on an interdisciplinary approach. Section 3 discusses the approach and methods used to undertake the quality improvement project.

Project Design and Methods

Several articles mentioned protocols to standardize bedside handoff (Holly & Poletick, 2014; Herbst et al., 2013; Bradley & Mott, 2013; Johnson, Carta, & Throndson, 2014). However, none of them identified a specific policy. Holly and Poletick (2014) pointed out that bedside handoff practice guidelines are difficult to implement without a policy to guide the bedside handoff. Therefore, a policy and relevant practice guidelines needed to be implemented through an interdisciplinary group (Menefee, 2014) led by the hospital's professional practice shared governance council. Only a set number of hospital

staff can write a policy—usually only executives and directors. A member of the planning committee collaborated with the CNO to edit the final version of the policy.

Once the policy was completed and approved by the professional practice council, practice guidelines were explained to the entire healthcare provider team. All learning activities, including in-services, are captured electronically, allowing clinical managers and educators to follow up on the entire health care team's progress. The plan called for the me to present the training to the educational council after approval was granted from the professional practice council. The group decided to assign presentation of the training to the committee chair. From the beginning of planning and discussion, I provided insight and education to all committee members about this quality improvement program. I identified potential conflicts in implementing this program since, at times, more than one organizational educational initiative is planned. On approval of the quality improvement project, the Ipresented an implementation timeline (Appendix E) that considers all other interdisciplinary educational initiatives. In the end, the training materials from the AHRQ will be used to simplify the training component of the implementation process and to reduce the time and cost needed to create a training presentation (Arora et al., 2008).

Overall Approach

In order to successfully improve communication within the hospital using a standardized handoff at the bedside, the training plan included the application of a change theory (Studer, 2003; Studer Group, 2013; Manchester, Gray-Miceli, Metcalf, Paolini, Napier, Coogle, & Owens, 2014), an adult learning theory (Anderson & Wilson, 2009),

and organizational systems theory (Gardner, Gardner, & O'Connell, 2013; Studer, 2014; Spaulding et al., 2010). One message repeated throughout the literature review was the need for a policy to identify and define specific processes and practice guidelines. The policy, practice guidelines, and learning courses had the theoretical foundations that facilitated approval by the lead committee and executive leadership. The current practiced leadership concepts by Quint Studer assisted in bringing all of these theories together under the umbrella of "hardwiring excellence" (Studer, 2003). Instead of creating a new process and presenting bedside report using IPB, the movement of handoff to the bedside was presented as a transformation of practice (AHRQ, n. d.; AHRQ, 2012; AHRQ, 2013; AHRQ, 2014; Pentland, 2011). The Studer principles of employee engagement and leadership rounding supported implementation of this project. The patient-centered focus of bedside report fit the mission and vision of the organization.

The group conducted the Iceberg exercise (Haider, 2009; AHRQ, 2014) during the discussion phase of the DNP project. The iceberg exercise identified potential cultural challenges, manage change and organizational systems limitations to implementation. The iceberg exercise (Haider, 2009, AHRQ, 2014) allowed me to identify the similarities in how the different disciplines to provide patient care (Herbst et al., 2013) across the hospital's healthcare disciplines. The iceberg exercise (Haider, 2009; AHRQ, 2014c) identified why we care for our patients and found common caring principles. The goal and expected outcome for this exercise was to bring together common caring and ethical principles that are shared among all of the disciplines within this organization. These common principles were the foundation of the practice guidelines and to close the gap

created by the multifaceted (Manning, 2006) lines of communication. For example, patient handoff from a physical therapist to a nurse would include patient self-care deficits and potential mobility issues. It is at this time, a change or adjustment to the interdisciplinary patient care plan might occur. These points of change or adjustments to the care plan are important to all healthcare disciplines and the patient. The nurse-led interdisciplinary team selected a nurse to chair the interdisciplinary committee and a non-nurse as a co-chair. The steps followed for this project are listed below:

1. Form an interdisciplinary committee recruited from the hospital's professional practice council.
2. Lead committee in a review of relevant literature (Appendix A).
3. Develop and submit committee charter identifying the committee leadership, timeline, stakeholders, and deliverables to the professional practice council (Appendix B).
4. Develop a policy (Appendix C) and practice guidelines (Appendix D) to guide the interdisciplinary application of IPB and bedside handoff.
5. Validate the content of the policy and practice guidelines via a review by scholars with expertise in the area of health systems communication and organizational communication.
6. Develop long-term plans for implementation (Appendix E) and evaluation (Appendix F and Appendix G) and any supporting resources needed for the primary products described above.
7. Formally submit all deliverables to the professional practice council.

Interdisciplinary Committee

The literature on bedside reporting using standardized communication was found mostly in nursing journals. As a result, the interdisciplinary committee contributed to expanding the knowledge and literature found during the nursing literature review for this project. The plan included a nurse-led interdisciplinary team (Costa & Poe, 2008) comprised of the different patient care disciplines found within the hospital. The interdisciplinary team mirrored the same healthcare disciplines and departments found within the professional practice council. The interdisciplinary team provided feedback in regards to the suggested processes, development of a new policy, and a review of current practices to identify if new practice guidelines needed to be created. I facilitated the planning and development of the committee, policy and guideline development, and provided support as needed to ensure that this plan was added to the agenda to be presented to the professional practice council.

Committee members were recruited from the members of the professional practice council. Each member requested a secondary committee member from his or her home department (Fray, 2011; Pinkerton, 2008). The goal was to have at least one additional team member to assist in the planning, development, and implementation of the planned project. In addition, if one team member was not available to attend meetings or provide updates to the entire council, the secondary might be able to provide feedback, suggestions, and contribute to the development of the project. A short presentation using the AHRQ materials about this program and expected outcomes was shared with each

department's unit based council. The plan was to add the presentation to the meeting minutes to keep all who read the minutes informed about the project timeline and goals.

Interdisciplinary Literature Review

Identification of non-nursing literature intended to bring together the different disciplines. Staggers and Blaz (2012) reported that the literature on bedside handoff is nurse specific and nurse focused. I presented a literature review, any current organizational policies addressing patient handoff, and any previous educational documents used for the first implementation in 2011. The literature review was updated to reflect new findings from development of this paper. All members of the committee were encouraged to participate in a literature review by discipline to identify additional information that could be added to the nursing literature review. Literature from other interdisciplinary journals positively contributed to maintaining the interdisciplinary focus needed to sustain the practice of bedside handoff. This interdisciplinary focus intended to encourage participation and ownership of the quality improvement project (Studer, 2003; Studer 2014). Members were given a copy of the keywords and methods used to identify possible contributions to the existing literature review. The keywords and core caring principles (Herbst et al., 2013) identified during the iceberg challenge exercise (Haider, 2009, AHRQ, 2014) were also included. Members encouraged to add to the suggested keywords and core caring principles as they related to each specific discipline. I encouraged feedback during these meetings and during the interdisciplinary literature search. The majority of the members participating in the interdisciplinary literature review gravitated to the AHRQ website.

Committee Leadership and Charter and Data Collection and Review

Once the committee membership was identified, the committee members selected department representatives to lead the department level actions in the implementation of the project (Fray, 2011). A chair and co-chair to lead the planning committee were elected. The chair and co-chair were responsible for creating the shared governance committee charter and presenting it to the rest of the interdisciplinary team members. The I collaborated with the chair and co-chair in reviewing all parts of the rollout plan and to create a charter. The charter described the plan with an emphasis that no data collection would occur until a baseline date was selected after implementation. The method of data collection was left up to the executive staff to determine at a later time.

The project deliverables included a timeline delineating team member responsibilities and tasks once the plan was approved by the council. The plan included a suggested measurement tool as part of the process of evaluation after the bedside report has been in place for a year. I recognized that the shared governance council is comprised of frontline staff with one executive level member. The frontline staff needed a guide to help them analyze the data that they will select to monitor after project implementation. The "how to" guide would demonstrate an example of what will be presented to the planning committee to allow them to decide a method of data collection after a six-month period. The "how to" guide was tabled by the council members.

The full evaluation plan will be developed by the implementation committee after deployment the of policy and practice guidelines. The final evaluation plan will be presented to the professional practice shared governance council for approval and

implemented according to the designated time as noted in the team charter. My role as a leader in this project reached completion when the implementation plan was delivered to the professional practice council. I emphasized that data would not be collected during the DNP project.

Policy and Practice Guidelines Development

The information gained from the updated interdisciplinary literature review, and the common core principles identified during the iceberg discussion, guided policy and practice guideline development. The decision was to keep the guidelines simple and direct. Studer's managerial concepts were applied to the practice guidelines and time table. I believed that executive leadership should be present during planning meetings to provide feedback concerning the policy and practice guidelines. While the bedside healthcare provider would see what was occurring within the unit, executive level feedback would guide policy development from an organizational and global view. An example of this could be an upcoming change in service line directorship or policies that were in development in other areas of the organization. The goal of this exercise was to create key areas of the policy that would support project sustainability. Once the challenges were identified, the literature review updated, and the educational course updated, an implementation toolkit was created. The final decision was to use the AHRQ toolkit that was readily available online. This would save time and allow the team to focus on implementation readiness.

Plan for Content Validation

The literature review did not yield a consistent form for protocol implementation. Stagers and Blaz (2012) pointed out the "high variability" (p. 248) of literature during the discussion of creating a process for bedside handoff. Variability was addressed by a plan for content validation. The plan for content validation was to present the literature review in a matrix form (Appendix A), practice guidelines (Appendix D), and a draft of the interdisciplinary policy (Appendix C) to the educational shared governance council. The individuals selected to provide content validation had a background on physician and nurse collaboration, communication, professional practice, and clinical research. The shared governance council included pharmacists and physical therapists with doctoral level education. The council used an organizational specific content validation process for all projects, posters, and podium presentations that are produced by members of the hospital. This quality improvement project was subjected to this process. The results were shared with the planning committee to determine if changes are needed in the policy and guidelines.

Nurses and other interdisciplinary clinicians reviewed the practice guidelines and a draft of the policy. The focus of the review was two-fold. One was to focus on implementing this practice improvement project using the current system processes. The second portion of this review was to identify any other possible processes that would be of better use other than the current processes. The organizational systems in place would support the performance improvement project without needing to introduce additional processes. The council reviewed the implementation plan and potential evaluation methods with a focus on the hospital's organizational systems. The council was to

communicate the findings, adjust all deliverables based on feedback, and expedite approval by the professional practice council.

Long-Term Plans for Implementation and Evaluation

Decisions of timing, project budget, and resource allocation was left to the implementation committee under direct supervision of the CNO. I provided the links, the spreadsheets, and steps to extract the data from the CMS Hospital Compare website to facilitate the implementation and evaluation of the project when the professional practice council decided to move forward with the project. This concluded the DNP's role within this capstone project. The implementation and evaluation of this project will the responsibility of the implementation committee under the guidance of the council after the primary (policy, practice guidelines, educational course) and secondary (implementation plan, evaluation plan) have been delivered.

Formal Submission of Deliverables

Project deliverables were presented to the hospital's professional practice council for review, editing, and approval. Each team member was responsible for providing feedback on all deliverables specific to his or her healthcare discipline. In addition, each committee member was encouraged to submit literature pertaining to standardized communication at the bedside as it relates to his or her discipline. I offered suggestions and guided the interdisciplinary team in identifying milestones by creating a committee charter including project deliverables and a timetable. The team charter, policy, guidelines, implementation plan, and plan for evaluation were all delivered to the implementation committee.

Summary

I ensured that all deliverables were included in a timetable upon approval of the project. The organizational policy or policies produced by this project would improve interdisciplinary communication in relation to patient handoff. The application of Studer's principles of excellence and employee engagement provided the support needed from the executive level to the bedside. Using the processes already in place within the organization assisted in not presenting new processes but just transforming the processes where patient handoff is moved to the bedside was a goal of this project. A final action was to communicate with the other shared governance councils and request assistance in the implementation of this project. There is not a need to reinvent the wheel. The key was creating an interdisciplinary team using processes already in place to improve the quality of communication. The challenge would be to remain consistent and the Studer model of hardwiring excellence would help meet that challenge.

Section 4: Discussion and Implications

Introduction

The project sought to improve the quality of communication among the interdisciplinary team members and subsequently improve patient satisfaction scores on communication (Sherman et al., 2013). I identified the organization's existing processes and tools that were used to standardize communication. In the past? not one process had been identified to be used during patient handoff or during interdisciplinary communication addressing patient care issues.

The goal of the project was to find a tool that would standardize communication among care providers to improve patient care communication and reduce variability (Riesenberg et al., 2010; Gonzalo et al., 2016). I suggested IPB and facilitated a discussion about other methods of standardization. The key was to move the handoff report to the bedside using a standardized format (AHRQ, 2013; Studer, 2010). I recommended IPB because all new hires and hospital employees received training on IPB. Using IPB would save time and financial resources.

I found members within the hospital's professional practice shared governance council and created a committee that submitted practice guidelines to standardize and improve patient handoff and interdisciplinary communication. The practice guidelines were based on an interdisciplinary literature review (Appendix A). The review of the current best practices reinforced my belief that the guidelines would meet the needs of the organization in closing the gap in patient care communication. I facilitated the development of a charter to be used by the committee to name the members of the

committee, set a timeline for deliverables, and identify other stakeholders in the organization. The outcome of the project was to deliver the final product to the professional practice council, where it would be reviewed by experts in the area of interdisciplinary health systems communication. The committee did not collect data but created and recommended a long-term implementation plan and an evaluation plan. The suggestion for gathering data and evaluation was the hospitalcompare.gov website. I believed that quick access guide would help in navigating the website. The quick access guide was tabled by the committee. It was decided that the organizational leaders would determine how to disseminate the collected data after implementation. The decision makers in the organization would determine how to help frontline personnel actively participate in observing and tracking patient care satisfaction scores after implementation. All deliverables were to be submitted to the professional practice council for approval.

Discussion of Project Deliverables

This section will describe the following project deliverables in detail.:

1. Form an interdisciplinary committee recruited from the hospital's professional practice council.
2. Lead committee in a review of relevant literature (Appendix A).
3. Develop and submit committee charter identifying the committee leadership, timeline, stakeholders, and deliverables to the professional practice council (Appendix B).
4. Develop a policy (Appendix C) and practice guidelines (Appendix D) to guide the interdisciplinary application of IPB and bedside handoff.

5. Validate the content of the policy and practice guidelines via a review by scholars with expertise in the area of health systems communication and organizational communication.
6. Develop long-term plans for implementation (Appendix E) and evaluation (Appendix F and Appendix G) and any supporting resources needed for the primary products described above.
7. Formally submit all deliverables to the professional practice council.

Creation of a Committee

Preparing to present the practice improvement project and addressing the professional practice council was the first step to initiating the project. I intended to guide the professional practice council through the information found on the AHRQ website in reference to bedside report. The AHRQ provides resources and tools ready for presentation to introduce bedside report to any organization that chooses to implement bedside report. The tools were of no cost to the organization and will reduced any conflict concerning the cost of implementing the project (Arora et al., 2008). The current training in IPB for all employees addressed possible concerns about the cost of additional training. These tools included an educational handout for patients, a checklist for nurses, and a training guide for health care providers. I recruited volunteers to become part of the interdisciplinary committee that were to lead the implementation of bedside handoff using IPB. The volunteers were from the nursing discipline and allied healthcare. The majority of the council was to be comprised of frontline nurses. The challenge was to explain the literature review and evaluation plan in a form that the frontline nurses would

understand. The literature review matrix (Appendix A) provided an at-a-glance preview of the different aspects of bedside report using standardized communication.

Interdisciplinary Literature Review

The interdisciplinary committee was introduced to the implementation handbook found on the AHRQ website. All of the materials found on the AHRQ website are prepared and ready for deployment within the nursing discipline. The committee modified the tools to fit the interdisciplinary communication needs of the organization. Interdisciplinary peer-reviewed literature was used to create a policy and practice guidelines to meet the communication needs of the organization. The literature review assured the integrity of content found within the interdisciplinary practice guidelines. After the literature review, the committee selected a chair and co-chair to lead the implementation process assuming the project was approved by the professional practice council.

I requested that members from the committee work with the nurses who did not understand the purpose of the literature review. The DNP lead's concern was potential lack of engagement by frontline nurses unfamiliar with literature reviews. The frontline nurses would provide the rationale to the rest of their units. It was imperative that the nurses be prepared to answer questions. By participating in compiling the literature review or studying that literature review, the frontline nurses would gain the knowledge needed to explain the process and expectations to the rest of the unit. After reviewing the literature review matrix, a member of the committee believed that the committee should change the technical writing to a narrative form. I asked the committee to agree upon a

course of action to facilitate nurse comprehension. In the end, the informational packets and tools found on the AHRQ website were chosen for their ease of use and understanding by the frontline nurses who volunteered to read and share what they learned.

Project Charter

The committee created a charter outline for the project was based on the Lean Six Sigma (Go Lean Six Sigma, 2016a; Go Lean Six Sigma. 2016b; Go Lean Six Sigma. 2016c) project improvement processes. The charter was a one-page sheet that provided key information concerning the performance improvement process. The charter was to identified the name of the project, leaders, sponsors, team members, background, objectives, assumptions, constraints, deliverables, and measure of success. Appendix B lists the components and a brief explanation of each component. Each committee member was asked to review and make suggestions to the charter. The charter was to be presented to the Professional Practice Council for approval. The final and approved charter would be presented to the CNO as identified within the by-laws of the shared governance council. It was expected that the CNO would approve. The committee expected to present a short overview of the project that included suggested implementation and evaluation plans.

Hospital Policy

The policy (Appendix C) and practice guidelines (Appendix D) were discussed within the committee. Each discipline presented the primary focus of each discipline as it pertains to communication and practice. The most important foci (Gleddie, 2016) were

included in the policy and practice guidelines. The AHRQ website presented the iceberg as a tool to manage change and create a culture of sustainability. The exercise allowed the committee to identify some issues. The common issues that were identified by each discipline, would be addressed by the policy. One challenge identified was the perception of the allied health care team that nurses were reluctant to be part of the bedside report from other disciplines. To reiterate, there was a perception of reluctance but no data were collected to prove or analyze if there was a reluctance. Measuring the attitudes of nurses could be an optional study for the implementation committee at a later time. The policy became too cumbersome and at one time it was more than three pages long. A compromise was reached to keep it simple but to ensure that all patient care information was shared at the bedside.

The practice guidelines attempted to close the gap in communication and multiple levels of communication. The policy and practice guidelines should be released by a member of the executive team to all employees via the policy and procedure system. The employees were to receive an email to review the policy and acknowledge the policy prior to implementation. The policy in Appendix C was the first deliverable for this project. The challenge was to create an interdisciplinary policy that all members of the healthcare team would understand and be able to follow. Based on the findings of the literature review, it was decided that UAP's would also participate in a short bedside report at handoff (Howard & Becker, 2016).

Practice Guidelines

The practice guidelines were to include strategies for sustainability including project sponsorship and support by upper-level executives. The policy and practice guidelines were reviewed by a member of the Empirical Council before being submitted to scholars with expertise in organizational communication as it pertains to healthcare. The feedback provided by the council member was to add the bedside report policy and guidelines to executive grand rounds for monthly follow-up. Appendix C presents an outline that every policy within the organization must follow. The example in Appendix C includes the title of the policy, purpose, definitions if any, practice guidelines, and references. The organization requires sources for the policy and practice guidelines must be peer-reviewed journals and be evidence-based practices.

I believed that using the guidelines from the AHRQ would ensure the most up-to-date evidenced-based practices and would be the primary resource. A strong recommendation from a content expert suggested that the policy stay as simple and concise as possible and that the plan for sustainability, sponsorship, and support be outlined in the charter. The AHRQ provides an entire toolkit to roll out bedside report. This toolkit is public domain and offers a checklist, guidelines, and PowerPoint presentation to be used to implement the program. The PowerPoint presentation includes spaces within the presentation to add the organization's name and spaces to personalize the presentation the organization. The guidelines for bedside report were written and are demonstrated in Appendix D. Although the toolkit is free and readily available this author suggests that everyone organization should perform an organizational culture analysis to identify potential barriers prior to implementing the toolkit.

Deliverables and Major Milestones

I identified long-term plans for implementation and evaluation. Timing and major milestones were agreed upon by the committee. Major milestones included dates for expert content review, implementation and future dates for evaluation. The expert content review and subsequent feedback occurred rather quickly and the project moved towards being added to the professional practice agenda for final presentation. The DNP accepted the suggestion to name specific offices not officers or executive titles not the names of the executives within the charter. In other words, if there was a change in the person fulfilling the role of CNO, the CNO would still be held to the commitments outlined in the charter. This proved to be beneficial since there was a change in leadership during the time of presenting the project and awaiting approval.

Implementation

The hospital had an existing process for implementing organizational-wide projects. I believed that the committee needed to be aware of the rollouts of any programs and hospital-wide initiatives that might cause a conflict with the rollout of bedside report. For example, the implementation of bedside handoff might conflict with new equipment training. The global overview of hospital-wide and unit based initiatives would assist the committee to be aware of potential conflicts. The scheduling of project implementation needed to steer clear of overburdening the nurses, staff, and educators. The committee decided to circumvent conflicts for frontline nurses, nurse managers, and educators having to decide between two high priority projects and not rush the process but instead observe and designate the best time possible.

The future scheduling of the implementation of the project created difficulty in setting specific dates. The committee reviewed upcoming initiatives and provided potential start dates. Therefore, the implementation plan did not contain specific dates but contained a date range or generalized timing of certain actions needed to implement this project. The implementation plan included a date range that was based on an initial rollout date. I lead believed in allowing the nurse managers to decide what day the rollout should occur. This approach supported buy-in and avoided high priority conflicts. For example, the nurse manager might sense a priority conflict if there were other unit specific rollouts occurring at the same time. The nurse managers will avoid a sense of conflict if they are able to identify the day of implementation and report that day to the committee. The implementation plan included details such as unit based council meetings, or in-services, the agenda, attendees or the individuals responsible for leading the implementation of this new project. Members of the implementation team responsible for follow through on the set milestones and goals of the implementation plan were identified. The team members identified would also be subject matter experts case there is a need for further education.

Evaluation

The evaluation plan was the biggest issue. Although data would not be collected until a year after implementation, there were individuals in the committee who wanted to begin gathering data immediately after implementation. The patient satisfaction scores run about three months behind the current month so gathering data right after implementation would allow the managers to identify a baseline. The higher level

executives desired an evaluation plan that would include the mean, the mean ranking, percentage of the top row box, a report that included the top, middle and lower rankings. Some nurse managers wanted to report weekly, and others quarterly.

The nurse managers wanted to select goals for the units or departments that they supervise. The nurse managers will identify the goal and report it to the executive level managers and directors (Appendix G). One manager wanted to apply a pre-test and post-test to measure outcomes. A compromise was made. Each nurse manage could gather data according to his or her preferred methodology. In the end, a compromise was reached. The goals and statistical evaluation of the outcomes would be decided by the executive leaders. The compromise did not fit the DNP lead's vision of agreeing upon a unified method of goal setting and reporting. The compromise was made to keep the planning, discussion, and implementation on track.

There were some nurse managers who wanted to measure all of the domains dealing with communication. The DNP encouraged them to keep the evaluation process simple and focus on the four domains chosen by the council members. There was nothing to impede collection of data of other components, but the I wanted to keep the nurse managers and executive level staff focused on the original components. The compromise suggested was to focus on the four components and as the domain scores reached and stabilized in the top 95th to 100 percentiles, another domain as it relates to communication could be chosen and evaluated. It is entirely possible that the CNO might decide to identify one specific method and request that the nurse managers use the one specific method.

The frontline nurses within the committee believed that not all frontline nurses understand means and linear values as reported by HCAPHS. The frontline nurses wanted a simple report to inform the frontline nurses of changes from the baseline per month (Appendix F). The frontline nurses expressed concern that specific statistical methodology included in the report may cause nurses to lose interest if they do not understand the relevance of that data. The group wanted a comparison between baseline and the current reporting month. The comparison was to be reported in percentages. For example, 76 percent of the patients interviewed say they will always recommend the hospital. If the 76 percent is the top value, then the number would be highlighted in green. If the low box percentage increased, the percentage number would be reported; then the number highlighted in red. The final decision was to use simple percentages in either a green or red color or an arrow on the side of the box to demonstrate an increase or decrease from the previous update. Data collection was not part of this DNP Project. I lead created a timeline based on the decisions made by the committee for data collection and evaluation. All committee members reviewed, provided feedback, and approved the policy, timeline, the major milestones or deliverables, and charter.

Content Validation

The completed policy with practice guidelines and project charter was intended to be submitted to the professional practice council, empirical outcomes council, and subsequently, the executive council. Submission of the completed policy and practice guidelines to the implementation committee ended the DNP's project. At this point, the DNP adopted the role of subject matter expert as needed. The committee chair was to

follow the plan for content validation. The committee chair was to present the policy and guidelines to the professional practice council after receiving feedback from experts in the field of organizational communication. Appendix D demonstrated a suggested checklist to be followed to keep the team on track with deliverables. The key components were identified and added to the charter. The checklist identifies certain tasks that will occur simultaneously or consecutively.

Implications

The implications of this project included positive practice improvements (Taylor, 2015), increased patient (Sherman et al., 2013; Grimshaw et al., 2016) and practitioner satisfaction (Gregory et al., 2014) with communication, standardizing and identifying one specific method (Stagger & Blas, 2012; Chapman et al., 2016) of communication as it relates to patient handoff and care. Standardized communication during bedside handoff breaks away from the long-standing and traditional method of patient handoff (Sherman, et al., 2013; AHRQ, 2013). Improved communication would improve the healthcare provider's satisfaction with the care provided to patients (Anderson & Mangino, 2006). Patient satisfaction as it relates to communication with nurses and doctors was expected to improve. Although data would not be analyzed until at least a year after implementation, the literature review indicated the project would improve patient satisfaction with the overall care received.

Strengths and Limitations

Strengths

The strengths of this DNP Project were that bedside handoff using standardized communication fit the organization's quality improvement initiatives. Bedside handoff breaks with tradition and puts the patient at the center of care. The project was evidenced-based and interdisciplinary. The project had buy-in from all of the healthcare disciplines because it fulfilled a need identified by the professional practice council. The project was validated by the planning committee, the shared governance council and experts in the field of communication as it relates to patient care.

Limitations

The limitations of the project were the amount of time required for the hospital to receive patient satisfactions scores. One area that concerned me was assuming that the organization would allow access to the policy writing software after the policy had been approved. Each discipline has a limited amount of policy writers. One way that the I attempted to overcome this challenge was to write the policy and practice guidelines and submit them in a format ready to be published. Modifications to the policy and practice guidelines might threaten the validity and integrity of the project. Another limitation was that the Idid not know how many individuals would volunteer to participate in this project after approval. Another limitation was the inability to agree upon one statistical method to set goals and compare outcomes. Lastly, the literature review did not yield a policy and procedure for standardized communication at the bedside using IPB to handoff patients. At the time of turning the project over to the professional practice council for implementation, I was unable to compare the submitted policy to the original draft.

Analysis

Analysis of Self

I believed that the project would change how patient handoff occurs within the organization. As a practitioner, I observed how patient care practices improved if the patient is at the center of handoff report. I foresee improved communication between disciplines, especially within the unit of employment. I work alongside different disciplines daily and envisioned closing the gap in communication if handoff occurred at the bedside. The most difficult challenge for me was to handover the project once all details were finalized. As a student, I would not be able to see how the project moved forward

As a scholar, I will continue to review the literature concerning standardized communication during patient handoff. One unknown variable involves new technologies that the organization might bring to the bedside. I recall a time when electronic charting was being implemented. As a bedside nurse, I could see that notes were being written about the patient and plan of care, but that information could not be accessed because of technological limitations. I will remain up-to-date on technologies expected to influence interdisciplinary communication.

I am experienced in project management. In a prior career, I managed several projects in multiple locations. One effective management tool involved identification and correction of mistakes early in the process, thereby limiting repercussions to clients and staff. In healthcare, the repercussions could be the cost of life or limb. Standardizing interdisciplinary communication will improve the safety (Lupieri, Creatti, & Palese, 2016) of patients and the method in how the organization communicates with each other

and with each patient. Hospital financial viability is influenced by VBP. Patient satisfaction is part of reimbursement. If there was a way to improve patient satisfaction, reduce patient errors, improve patient safety, I felt an obligation to present the project as a method for improving overall interdisciplinary communication within the organization. Although IPB was intended to be the principal standardized method of communication, part of the hospital units rolled out with SBAR, while one service line chose to use IPB. I believe that if a set method of communication is used at the bedside, patient care outcomes will improve.

I researched the different systems in place within the organization as they pertain to communication. The knowledge gained through this exercise provided an opportunity to improve understanding of communication as related to patient care issues and priorities. Improved communication provides an opportunity to bring together the different foci of each discipline. The literature review created some "ah ha" moments when reflecting upon previous interdisciplinary communication and patient care instances in which communication could have been directed towards understanding the focus of each discipline. This knowledge will me in strengthening current interdisciplinary collaboration between herself and other healthcare providers. Improving healthcare provider communication will provide a long-lasting subject for life-long learning.

Summary

As I reviewed the different disciplines and their method of communication, I expected to learn how to adapt future communication initiatives based on the knowledge gained during the project. Lessons learned are to that the practice guidelines were written

in a succinct manner and in a nonprescriptive manner. I believed the shorter the policy, the less points for discussion or dissention. A prewritten policy and approved by committee demonstrated planning and forethought. Medicare and VBP will continue to push organizations to continue to review and improve all systems and processes as they pertain to patient safety and improving the quality of care to increase profits. I believe that I should have included the CFO into some of the discussions about how improving patient satisfaction scores would positively impact the hospital's finances. The charter identified key job roles that could ensure that the project stays on course. Sustainability is the charter's primary purpose after implementation. Use of the free and preprinted AHRQ materials reduced the cost to this initiative awhile improving patient care outcomes reduced project expenditures.

Section 5: Scholarly Product

Introduction

Manning (2006) wrote that healthcare communication is challenging due to the different focus of each specialty. Manning noted that the focus of the healthcare specialty is what drives how a healthcare provider communicates to the patient and other healthcare providers. The center of attention of each specialty causes a change in the type of communication (Lane-Fall, Speck, Ibrahim, Shea, McCunn, & Bosk, 2014). It is this focused communication that could cause a perceived variation between each discipline (Gonzalo et al, 2016). Variation of communication is what could contribute to a communication gap between healthcare disciplines (Manning, 2006; Clancy, 2009). This gap contributes to a sense of dissatisfaction with the quality of communication between healthcare providers (Griffin, 2010).

The patient might perceive the different channels or foci of the healthcare practitioners as ineffective or inconsistent communication. In addition, the variability of the channels of communication between the disciplines creates an opportunity for patient injury and threatens patient safety (AHRQ, 2013; Wolosin et al., 2012, Scovell, 2010; Brown & Sims, 2014; Lupieri, Creatti, & Palese, 2016; Gonzalo et al., 2016). For example, a patient with comorbidities such as COPD, CKD, and heart failure will be managed by more than one specialty. Upon admission into an acute care center the patient might be visited by all of the patient's healthcare providers. There might be enough variation in the messages being conveyed (Lane-Fall et al., 2014; Parush et al., 2014; Gonzalo et al., 2016) to the patient to cause the patient to become confused about

the pending outcomes and discharge expectations. This confusion might negatively influence a patient's adherence to his or her care plan. The patient might perceive a lack of communication or miscommunication among the disciplines and be dissatisfied with the care provided during admission (Ofori-Atta et el., 2015). The lack of satisfaction with communication and the perceived ineffective communication creates a distrust in the care being provided (Grimshaw et al., 2016). Communication at the bedside with the patient at the center of care and focus will reduce that sense of miscommunication and variability (Baker, 2010; Salani, 2015; Robbins & Dai, 2015).

Problem

The project tackled poor communication between healthcare providers as identified during a shared governance council's discussion of organizational needs. The perception of poor communication existed even though the hospital had several processes in place to guide communication between all healthcare providers. These processes existed but the organization lacked a policy and practice guidelines that identified specific methods of communication. For example, all new hires since 2006 had received training in using TEAMSTEPPs and I PASS the BATON (IPB) but after the new hire training, the hospital lacked a structured method of applying the training to every day practice. TEAMSTEPPs identified IPB as the standardized method of communication but some units only used SBAR. Other units used a different form to communicate patient information during transfers. One unit used a written form to communicate patient transfers and handoffs, but the nurse transferring accountability did not provide a face-to-

face report to the receiving nurse. The written handoff report was the only report the accepting nurse would receive.

The lack of consistency in methodology and sharing handoff report away from the patient did not fit the hospital's mission and vision of patient-centered care. In addition, the transfer of the patient away from the bedside, did not fit the patient and person-centered focus of the hospital and CMS. The AHRQ (2013) mentioned that patient satisfaction is directly linked to a patient's perception of communication between nurses and doctors. Standardizing communication at the beside between all healthcare providers should improve patient care outcomes, patient satisfaction, and possibly healthcare provider's satisfaction with the care provided to the patient (Scovell, 2010, Brown, 2013. Bradley & Mott, 2013; San-Jecklin &
Sherman, 2014 Grimshaw et al., 2016). Standardizing communication reduces variability in communication (Stagger & Blaz, 2012; Salani, 2015) and is patient-centered (Anderson & Mangino, 2006; Radtke, 2013; Taylor, 2015; Chapman et al., 2016) and contributes to improving patient safety (Lupieri, Creatti, & Palese, 2016).

Purpose

The performance improvement project aimed to create interdisciplinary practice guidelines and an interdisciplinary policy that identified IPB as the standardized method of communication. The interdisciplinary guidelines intended to move the transfer of patient care using standardized communication to the bedside. The guidelines encompassed nurse-to-nurse transfer of patient accountability to the bedside and interdisciplinary guidelines to be used whenever someone other than the primary nurse

cared for the patient (Chapman, 2016; AORN, 2012; AHRQ, 2013). The policy included guidelines that moved all communication pertaining to patient care and care outcomes to the bedside. A committee comprised of volunteers from the a shared governance council were charged with implementing the program once it was approved. My role was clearly outlined as the leader of the planning and development of the practice guidelines, and the committee would be in charge of implementation and subsequent evaluation. Data were not collected during the DNP Project. The interdisciplinary committee created the timeline to roll-out the project to avoid competing with the implementation of other programs or training priorities. The purpose was to identify any possible conflicting priorities.

Goals and Outcomes

The goal of the project was to improve interdisciplinary communication and move the transfer of accountability to the bedside. The literature review (Appendix A) revealed that bedside report is patient-centered, increases nurse satisfaction with communication and subsequently increases patient satisfaction with his or her care while in the hospital. In order to attain the goals, the committee would have to discuss what each member expected to gain from the project. The discussion of expectations would allow me to apply Manning's (2006) suggestions to close the gap and bring together the different channels of communication. Once expectations were discussed and identified (Studer, 2014; Haider, 2009; AHRQ, 2014), the team would need to decide on the potential deliverables. The development of the practice guidelines (Appendix D) and policy (Appendix C) was the priority. Another desired outcome was to find stakeholders in all

disciplines as well as administrators to champion (Brewster et al., 2015) the committee priorities as needed. I encouraged the implementation team to consider creating a training course or an addendum to the current new hire training and highlight the new policy and practice guidelines. The committee wanted to focus the opportunity to increase patient satisfactions scores I kept them focused on priorities of the project. I did remind the committee that the performance improvement project was going to be a long term project and that the opportunity to evaluate any changes in patient satisfaction should occur at least six months after implementation and after the I handed over the project to the committee.

Although no data were collected and reviewed during this DNP Project, iexpected an increase in several domains of HCAHPS a year after implementation (Studer, 2014). The domains that would increase would be of nurse communication during the patient's hospital stay; physician communication during the patient's hospital stay; a patient's likelihood to recommend the hospital; and the overall rating of the hospital (CMS, 2013). The committee would be responsible for collecting data a year after implementation under the direction of the executive leadership.

Significance of the Project

Improving communication between healthcare providers protects the patient and improves care outcomes (Sherman, et al., 2013; AHRQ, 2013; Studer et al., 2010; Taylor, 2015). The project moved nurse-to-nurse patient handoff to the bedside. The move to the bedside would break with a longstanding tradition of handing off patients away from the bedside (Sherman et al., 2013). Traditional handoff occurs at the nurse's station and is

given at the same time that all other disciplines are handing off from one shift to another. The project would require that all healthcare provider handoff at the bedside. For example, a physical therapist would communicate care priorities and expected outcomes with the nurse at the bedside (Manning, 2006). This action would include the patient and the patient's family (McMurray et al., 2010; Baker 2010; Griffin, 2010; Brown & Sims, 2014). The nurse in charge of the patient would discuss how she or he would incorporate what was discussed into the current plan of care. This discussion would be conducive to reminding the patient and family that their wellbeing and healthcare was important to all providers. The project produced a policy and practice guidelines. Different practice guidelines were discovered during the literature review (Appendix A) but not one article to date has produced an interdisciplinary evidence-based policy. Appendix D demonstrates a concise example of a nurse-to-nurse handoff policy and an interdisciplinary handoff policy.

Bedside handoff using standardized communication puts the patient at the center of handoff and care. This action fulfilled the patient and person-centered mission of the hospital and should contribute to improved patient satisfaction scores. All of these goals fit in with CMS' directive to improve VBP reimbursement and quality improvement (Weeks & Weinstein, 2014; CMS, 2013). The potential to reduce patient care errors, decrease the number of undesirable and negative clinical care outcomes, and improve the quality of the information shared during handoff, all point to improving the quality of care. Improvement of care should reduce the number of treatment days and maybe re-admission (Studer, 2013; AHRQ, 2013; Radtke, 2013; Chapman et al., 2016).

The project would enable the hospital to transform how all health care providers communicate with each other as to the care interventions provided (Sherman et al., 2013;Studer et al., 2010; Spaulding et al., 2010; Bradley & Mott, 2013; Cornell et al., 2014;Stagger & Blaz, 2012). For example, if a patient is sent to radiology, the nurse and the radiology tech will handoff at the bedside. Pertinent information such as allergies, code status, reason for exam, and post procedure patient education will be discussed in front of the patient instead of just sending the patient to radiology without discussing key information.

No patient data were collected and reviewed during the DNP Project. The decision makers of the organization decided how the data will be collected and disseminated a year after implementation. The evaluation of data was to be forwarded as a research project for the shared governance council. The year-long wait before data will be analyzed was designated to allow the bedside staff to develop the skills (McMurray et al., 2010; Manning, 2006; Thomas & Donohue &-Porter 2012) needed to become proficient at handing off patients at the bedside. The interdisciplinary approach allowed all members of the health care team to participate in an evidence-based approach to teamwork, collaboration, and effective communication.

The breaking with tradition of handing off a patient away from the bedside created a paradigm shift. All nurses and healthcare clinicians will need to step away and reflect upon his or practice and identify how to adapt to the change. McMurray et al. (2010) was specific in mentioning the need to develop new skills as it pertains to communicating with a patient and in front of a patient concerning the patient's plan of

care. Handing off at the bedside using standardized communication is a tangible demonstration of finding methods to improve the quality of care, which in turn, positively contributes to potential VBP reimbursement (Staggers & Blaz, 2013), patient safety, and patient satisfaction.

Sherman et al., (2013) believed that the patient perceives being at the center of care with bedside report. The perception of centeredness creates a sense of confidence in the healthcare providers, nurses, and interdisciplinary team. The self-perceived confidence increases patient engagement in his or her care plan. Baker (2010) believed that is was the confident engagement in care that reduces patient anxiety and increases the patient's trust in the providers and care plan. Although the DNP did not find robust data or any type of study that proves that a patient's trust in the providers increases adherence, many of the journal articles found during the literature review suggested that increased adherence to the care plan is a possible outcome. Speculatively speaking, there are several potential areas of study that could reviewed a year after implementation in addition to measuring changes to patient satisfaction.

Interdisciplinary Literature Review

An interdisciplinary literature review was essential in bringing together all members of the committee and creating an interdisciplinary foundation for the policy and practice guidelines. Conversely, the interdisciplinary team would be able to contribute to the foundation by adding additional information to the literature review. The team was directed to the AHRQ which provided the tools needed to implement beside report. The interdisciplinary review found several different practice guidelines and suggestions for

implementation (Sherman et al., 2013: AHRQ, 2013B; AORN, 2012). The committee decided to incorporate the AHRQ tools for implementation as it was agreed that it was from the most reliable source. In addition, the tool kit provided by the ARHQ, included pre-published material, PowerPoint presentations, patient education guides, and training support tools. The tools would facilitate the implementation of the project and the cost of the portion of the project would be limited to printing and distribution .

The DNP conducted a literature review (Appendix A) for this project using several databases; the goal of this review was to fill in any missing gaps. The literature review identified several types of research, several practice guidelines from acute care centers, and organizational position statements in regards to bedside report. One key issue concerning the dissemination of data for implementation was the reading literacy and overall educational levels across the organization. Entry level for the different disciplines at the hospital ranges from a two-year degree in applied science to a doctorate degree. This insight provided possible challenges that the I might face when addressing the bigger interdisciplinary audience found within the councils. The challenge was answered by bringing in the AHRQ website and educational materials into the implementation process. Just as healthcare disciplines have different lines of foci of communication, I and other members believed that the AHRQ was easy to understand and reduced the gap in communicating to the healthcare providers the importance of moving handoff to the bedside. All involved would be receiving the same information, from the same location, at any time the providers wanted to access the information.

The literature review did not yield a policy to aid an organization in implementing bedside report. One of the deliverables of the project was a policy to be used to implement bedside shift report. The policy went through several changes, edits, and in the end, a succinct but clearly written policy was considered a better instrument. The guidelines were written with the intention of being used as a guide and not to be prescriptive. Prescriptive guidelines could have been perceived as too rigid and the healthcare practitioners should be focused on the patient; not of following strict guidelines. The benefits of bedside report are repeatedly emphasized in the interdisciplinary literature review and the individuals providing education and in-services concerning the change in patient handoff would be able to use the literature review matrix as a resource in addition to the information from the AHRQ website.

Theoretical Foundation

The different foci of each specialty that provides care for a patient varies and is multifaceted. This variation in communication increases the vulnerability of the patient. Manning (2006) identified each interdisciplinary foci as a channel. The different conduits of information need to be brought together. Clancy (2009) believed that the standardizing of communication will bring the conduits together. The AHRQ (2013) pointed out that moving the patient handoff and sharing of the patient's plan of care and patient information at the bedside is key to improving patient safety and quality care outcomes. The performance improvement project provided a process in which patient communication was shared in a concise and comprehensible manner that would bring key components of communication and patient care needs together. The organization's

leadership within the council acknowledged that closing this gap fits the goal of patient-centered care (Studer, 2003, Spaulding, et al., 2010; Pentland et al., 2011; Lane-Fall et al., 2014) and improves the quality of patient care.

During the discussion and planning stage of the project, the committee and I reviewed the different systems and processes in place within the organization. The goal of review the systems and processes was to identify processes that would support the implementation of the project and sustainability of the project (Haider, 2009). I believed that the organization had enough processes in place that would reduce the need to bring in new processes and reduce the time in planning and implementing the project. Combining current processes would avoid the need to introduce new processes and systems within the organization.

The committee and I believed that if new processes were introduced, the time for implementation would increase. All new processes would need to be discussed and approved within the shared governance councils and discussion of the new processed would take time and cause additional delay. Instead of starting from scratch, the committee combined current process already in place to fit the requirement of moving handoff to the bedside. In addition, selecting current processes would reduce the amount of training required to successfully rollout the performance improvement project. The project would be presented as a compilation of current processes that would be moved to the patient's bedside to improve patient outcomes.

The hospital adopted TEAMSTEPPS as the team building process to be used in interdisciplinary communication. The AORN (AORN, 2012) and TEAMSTEPPS

(AHRQ, 2016) identified IPB as the method of standardized communication to be used in interdisciplinary communication. The hospital trains all new hires in IPB, therefore training employees on standardized communication would not be an issue. Since training all of the new hires in using IPB was and continues to be part of the new hire orientation, the cost of training employees was already built into the new hire training budget (Arora et al., 2008). These were several rationales for selecting IPB as the framework for the organization's standardized communication. I and the committee believed that there was not a need to look beyond IPB since all employees were already trained on this form of standardized communication. By incorporating a system currently in place, there would not be a need to "reinvent the wheel" so to speak. The committee then moved forward to identify other processes already in place that would provide frameworks to implement and sustain the project.

The organization had adopted several management and leadership frameworks from the Studer Group (Studer, 2003; Studer, et al., 2010; Studer, 2013; Studer, 2014). The specific framework for implementation and sustainability is found in Studer's "*Hardwiring Excellence: Purpose, Worthwhile Work, Making a Difference* (2003) book. According to Studer, change must occur at all levels of the organization. All members are responsible in participating in changing a practice and no matter what role an individual fulfils within the organization, the responsibility falls on each one to change. The change must be behavioral and transformational. The bedside personnel initiated the change, and administration would round to support the change. The change had to be principle based (patient-centered) in order to be hardwired into the organization. Studer continued to

emphasize the need to hardwire organizational process to sustain performance improvement projects (Studer, 2010; Studer, 2014). The principles of delivering patient centered care, improving patient care outcomes, and transforming current practice to evidenced based practice fit the Studer framework.

Trochim (2006) believed that when attempting to create interdisciplinary change, all parties must agree on the same ideals or principles that will bring them together in a goal oriented fashion. These goal oriented principles should be mapped according to concepts. The hospital's patient-centered care focus, the culture of values, the professional practice model, patient care delivery model, and creating a culture of safety were all concepts that fit the goal of standardizing communication at the bedside. It is through these concepts that the organization would sustain any change that fits the principles mentioned beforehand. Studer (2010) suggested that principle based change creates a passion for excellence that is conducive to hardwiring or long term integration of concept based change. The daily huddles and leadership rounds that were already in place would provide an additional impetus for change and support sustainability. The charter assigning responsibility to the office or job title instead of a specific person, would keep the responsibility of follow up tied to the job function and not to one person. Tying the responsibility of follow up, data gathering and analysis, and sustainability to a job title such as director or office such as CNO, would stay the same even if the person fulfilling the duties of that job function or office were to change.

The on-going training of all employees and new hires on IPB was a process that would help with implementation. For example, the cost of training is already absorbed by

the human resources department. The cost of yearly training was already absorbed by the different units because yearly training and competency check-off is already in place. The cost of training primary care providers new to the organization is absorbed by the medical continuing education department (Arora et al., 2008). The focus would be to ensure that handoff report was occurring at the bedside using the process already in place.

The Studer Group (Studer, 2010; Studer, 2014) and other concept analysis publications (Sherman, et al.,2013; AHRQ, 2013) identified bedside handoff as an evidence-based practice that contributes to patient and family-centered care. It is the connection between care providers and patients at the bedside that increases the patient's trust in his or her care. A policy (Appendix D) and practice guidelines (Appendix C) putting these processes together is what would be new to the organization. The project charter (Appendix B) would include follow up on the continued practice of bedside handoff in all leadership rounds, department huddles, department shared governance meetings, and ensuring that the educational course is part of the yearly organizational competencies. The AHRQ's educational course would need to be updated to reflect the change of moving report to the bedside and incorporating the interdisciplinary frameworks into the course.

The project would include revisiting current organizational processes such as TEAMSTEPPs, culture of patient safety, and the patient care delivery model. It was important to identify the recurring patient centered and quality improvement principles to aid in implementing the project. In other words, the healthcare clinician was not learning anything new, the change was to move the handoff report to the bedside using

standardized communication that the clinician should already be using. In addition, successfully improving communication within the hospital using a standardized handoff at the bedside, the plan included the application of a change theory (Studer, 2003; Studer Group, 2013; Manchester, Gray-Miceli, Metcalf, Paolini, Napier, Coogle, & Owens, 2014), an adult learning theory (Anderson & Wilson, 2009), and organizational systems theory (Gardner, Gardner, & O'Connell, 2013; Studer, 2014; Spaulding et al., 2010). The current practiced leadership concepts by Quint Studer assisted in bringing all of these theories together under the umbrella of "hardwiring excellence" (Studer, 2003).

Project Deliverables

Identification of Team Members

The connection between care providers is not limited to nurses and patients. The literature review (Appendix A) identified improved communication between doctors and nurses, doctors and patients, and nurses to patients. The bedside handoff and standardized communication between all disciplines was expected to improve communication between all disciplines (Hagman, 2013). The committee membership mirrored all of the different patient care disciplines. The practice guidelines were to be distributed to members of the radiology department, the lab, the pharmacy, and physical therapy department. The front line nurses within the planning committee expressed a desire to include the nurse assistants (Howard & Becker, 2016) in bedside handoff training and reintroducing IPB as part of the change of shift report.

Project Charter

The charter outline and key areas are identified in Appendix B. The charter followed the by-laws of the hospital's shared governance councils which follow the Lean Six Sigma project improvement processes (Go Lean Six Sigma, 2016a; Go Lean Six Sigma, 2016b). A charter is a one-page informational sheet identifying key deliverables, the individuals charged with implementing specific parts of the project, and any fiscal commitments needed at the time of implementation. The leaders of the committee were identified with the ultimate leader identified as the CNO. The planning committee discussed, agreed, and identified all aspects of the improvement project. This exercise intended to create another point for interdisciplinary collaboration and stakeholder solidarity. Any events in which a committee can work together in decision making should make a historical imprint of interdisciplinary collaboration. All committee members had several opportunities to review and suggest changes to this charter.

The project charter solidified the program. The major milestones were identified within the project charter. The milestones included the process for implementation, future dates for evaluation, and the decision makers that would decide the methodology for evaluation. The decision makers within the organization would decide how to report any changes in patient satisfaction as it related to communication after implementation and therefore after conclusion of the DNP lead's active participation in the project.

Data collection was not part of the DNP Project. The charter left the dates and methodology for implementation up to the administrative leadership to decide at a later time. Setting an approximate time for evaluation was important so that outcomes could be measured at a later date. The hospital had several doctoral level members within the

councils. These members had contacts within the area that were to be approached to validate the content of the project as it pertains to interdisciplinary organizational communication. Content validation occurred rather quickly and the project was returned to the committee without changes in processes, framework or timeline and with a suggestion to quickly implement the program. I handed off the project to the committee and thereby ended her role as lead and concluded her DNP project.

Summary

Standardizing communication at the bedside during handoff was expected to increase patient satisfaction. The organization needed to break tradition and was to move the handoff report to the bedside. The literature review and the foundational concepts by the Studer group pointed to increasing patient satisfaction. The interdisciplinary literature review identified increased healthcare provider satisfaction with the care they provided to patients. Although the policy (Appendix C) and the guidelines (Appendix D) were specific to one organization, these two tools are concise enough to be a foundation for any organization searching for such tools. The literature review did not yield a policy to aid an organization in implementing bedside report. One of the deliverables of the project was a policy to be used to implement bedside shift report. The policy went through several changes, edits, and in the end, a succinct but clearly written policy was considered a better instrument. The guidelines were written with the intention of being used as a guide and not to be prescriptive. The benefits of bedside report are repeatedly emphasized in the interdisciplinary literature review.

This paper contributed to the literature that pushes for change in how we handoff our patients. Standardized communication at the bedside is a positive change in which all parties will be engaged in the care of the patient. The tool used to standardize patient handoff discussed in this paper is IPB. This author would like the reader to take away one specific point; the tool used could be IPB or SBAR, or any evidenced-based communication tool (Abraham, Kannampallil, Almoosa, Patel, & Patel, 2014), but in order to improve patient outcomes, handoff must occur at the bedside and be standardized. If at all possible, make handoff an interdisciplinary practice not just a nursing practice.

The interdisciplinary approach allows the primary the nurse to see a more global view of his or her patient's care plan. The interdisciplinary approach using standardized communication at the bedside allows the patient to see how many team members are involved in his or her care. As the country moves into a new era in which healthcare reform is changing and parts of the PPACA are being either scaled back or repealed, healthcare providers must remain constant and focused on providing high quality patient-centered care. Years from now, patient satisfaction might not be as important in meeting reimbursement guidelines but the demand for improving patient care, patient safety, reducing variability in handoff, and closing the gap in communication between disciplines, will remain.

References

Abraham, J., Kannampallil, T. G., Almoosa, K. F., Patel, B., & Patel, V. L. (2014). Comparative evaluation of the content and structure of communication using two handoff tools: Implications for patient safety. *Journal of Critical Care, 29*(2), 311.e1-7. doi:http://dx.doi.org/10.1016/j.jcrc.2013.11.014.

Agency for Healthcare Research and Quality. (n. d.). TeamSTEPPS Home. Retrieved from http://teamstepps.ahrq.gov/

Agency for Healthcare Research and Quality. (2012). Improving performance on the AHRQ quality indicators. Retrieved from http://www.ahrq.gov

Agency for Healthcare Research and Quality. (2013). Strategy 3: Nurse bedside shift report. Retrieved from http://www.ahrq.gov/professionals/systems /hospital/engagingfamilies/strategy3/index.html

Agency for Healthcare Research and Quality. (2014). Guide to patient and family engagement in hospital quality and safety. Retrieved from http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/index.html

Agency for Healthcare Research and Quality. (2014b). Hospital Survey on Patient Safety Culture. Retrieved from http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/

Agency for Healthcare Research and Quality. (2014c). TeamSTEPPS 2.0: Module 8: Sizing Up the Iceberg Exercise Sheet. Retrieved from http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/fundamentals/module8/exiceberg.html.

Alvarado, K., Lee, R., Christoffersen, E., Fram, N., Boblin, S., Poole, N., ... Forsyth, S. (2006). Transfer of accountability: Transforming shift handover to enhance patient safety. *Healthcare Quarterly*, *9*(75-79)

American Nurses Association. (2013). Code of ethics for nurses. Retrieved from http://www.nursingworld.org/codeofethics

American Nurses Credentialing Center. (2014). Pathway Program Overview. Retrieved from http://www.nursecredentialing.org/Pathway/AboutPathway

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

Anderson, J. A., & Wilson, P. (2009). Knowledge management: Organizing nursing care knowledge. *Critical Care Nursing Quarterly*, *32*(1), 1 - 9.

Arora, V. M., Johnson, J. K., Meltzer, D. O., & Humphrey, H. J. (2008). A theoretical framework and competency-based approach to improving handoffs. *Quality & Safety in Health Care, 17*(1), 11. doi:http://dx.doi.org/10.1136/qshc.2006.018952.

Association of periOperative Registered Nurses. (2012). Patient hand off tool kit. Retrieved from http://www.aorn.org/Secondary.aspx?id=20849

Baker, S. (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.

Balik, B. (2010). 10 years after To Err Is Human: Are we listening to patients and families yet? *Focus on Patient Safety*, 1 -3.

Balik, B., Conway, J., Zipperer, L., & Watson, J. (2011). *Achieving an exceptional*

patient and family experience of inpatient hospital care [IHI Innovation Series white paper]. Retrieved from Available on www.IHI.org

Benson, E., Rippin-Sisler, C., Jabusch, K., & Keast, S. (2006). Improving nursing shift-to-shift report. *Journal of Nursing Care Quality*, *22*(1), 80 - 86.

Bluni, R., & O'Shaughnessy, J. (2009). Words that save. Ensuring that "never events" never happen. *Marketing Health Services*, *29*(3), 13 - 17.

Bradley, S., & Mott, S. (2013). Adopting a patient-centred approach: An investigation into the introduction of bedside handover to three rural hospitals. *Journal of Clinical Nursing*, *23*, 1927 - 1936.

Brewster, A. L., Curry, L. A., Cherlin, E. J., Talbert-Slagle, K., Horwitz, L. I., & Bradley, E. H. (2015). Integrating new practices: A qualitative study of how hospital innovations become routine. *Implementation Science, 10.* doi: 10.1186/s13012-015-0357-3.

Brown, J., & Sims, S. (2014). Nursing clinical handover in neonatal care. *Contemporary Nurse*, *49*, 50 - 59.

Bruton, J., Norton, C., Smyth, N., Ward, H., & Day, S. (2016). Nurse handover: patient and staff experiences. *British Journal Of Nursing*, *25*(7), 386-393.

Cairns, L. L., Dudjak, L. A., Hoffmann, R. L., & Lorenz, H. L. (2013). Utilizing bedside shift report to improve the effectiveness of shift handoff. *The Journal of Nursing Administration, 43*(3), 160 - 165.

Caruso, E. M. (2007). The evolution of nurse-to-nurse bedside report on a medical-surgical cardiology unit. *MedSurg Nursing*, *16*(1), 17 - 22.

Centers for Medicare and Medicaid Services. (2013). Hospital Compare. Retrieved from http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare.html

Centers for Medicare and Medicaid Services. (2014). *HOSArchive_20110801.zip (08/01/2011, Zip File, 22926 KB)* [Data file]. Retrieved from http://medicare.gov/download/HospitalCompare/2011/August/HOSArchive_20110801.zi

Centers for Medicare and Medicaid Services. (2014b). *http://medicare.gov/download/HospitalCompare/2012/July/HOSArchive_20120701.zip* [Data file]. Retrieved from Hospital Compare.

Centers for Medicare and Medicaid Services. (2014c). The Affordable Care Act: Helping providers help patients. Retrieved from www.cms.gov/Medicare/Medicare-Fee.../ACO-Menu-Of-Options.pdf.

Chapman, Y. L., Schweickert, P., Swango-Wilson, A., Aboul-Enein, F. H., & Heyman, A. (2016). Nurse satisfaction with information technology enhanced bedside handoff. *MEDSURG Nursing*, *25*(5), 313-318.

Chin, G. S., Warren, N., Komman, L., & Cameron, P. (20*11*). Patients' perceptions of safety and quality of maternity clinical handover. *BMC Pregnancy & Childbirth*, 11(1), 58 - 65. http://dx.doi.org/10.1186/1471-2393-11-58.

Clancy, C. M. (2009). Patient safety: One decade after to Err is Human. Retrieved from http://www.psqh.com/septemberoctober-2009/234-september-october-2009-ahrq.html

Cornell, P., Gervis, M. T., Yates, L., & Vardaman, J. M. (2014). Impacts of SBAR on nurse shift reports and staff rounding. *MedSurg Nursing*, *23*(5), 334 - 342.

Costa, L., & Poe, S. S. (2008). Nurse-led interdisciplinary teams. *Journal of Nursing Care Quality*, *23*(), 292 295.

Dufault, M., Duquette, C. E., Ehmann, J., Hehl, R., Lavin, M., Martin, V., ... Wiley, C. (2010). Translating an evidence-based protocol for nurse-to-nurse shift handoffs. *Worldviews on Evidence-Based Nursing*, *7*(2), 59 - 75.

Epstein, R. M., & Street, R. L. (2011). The value and value of patient-centered care. *Annals of Family Medicine*, *9*(2), 100 - 103.

Evans, D., Grunawait, J., McClish, D., Wood, W., & Friese, C. R. (2012). Bedside shift-to-shift nursing report: implementation and outcomes. *MEDSURG Nursing*, *21*(5), 281-292.

Ford, Y., Heyman, A., & Chapman, Y. L. (2014). Patients' perceptions of bedside handoff. *Journal Of Nursing Care Quality*, *29*(4), 371-378. doi:10.1097/NCQ.0000000000000056.

Friesen, M. A., Herbst, A., Turner, J. W., Speroni, K. G., & Robinson, J. (2013). Developing a patient-centered ISHHAPED handoff with patient/family and parent advisory councils. *Journal of Nursing Care Quality*, *28*(3), 208 - 216.

Frampton, S., Guastello, S., Brady, C., Hale, M., Horowitz, S., Smith, S. B., & Stone, S. (2008). Patient-centered care improvement guide. Retrieved from planetree.org

Fray, B. (2011). Evaluating shared governance: Measuring functionality of Unit Practice Councils at the point of care. *Creative Nursing*, *17*(2), 87 - 95.

Gardner, G., Gardner, A., & O' Connell, J. (2013). Using the Donabedian framework to examine the quality and safety of nursing service innovation. *Journal of Clinical Nursing*, *23*, 145 - 155.

Go Lean Six Sigma. (2016a). Project Charter. Retrieved from https://goleansixsigma.com/project-charter/

Go Lean Six Sigma. (2016b). Six Sigma Project Charter. Retrieved from https://www.isixsigma.com/tools-templates/project-charter/six-sigma-project-charter/

Go Lean Six Sigma. (2016c). Project Template. Retrieved from https://www.isixsigma.com/images/stories/migrated/downloads/charter.pdf?bb3c77.

Gonzalo, J. D., Himes, J., McGillen, B., Shifflet, V., & Lehman, E. (2016). Interprofessional collaborative care characteristics and the occurrence of bedside interprofessional rounds: a cross-sectional analysis. *BMC Health Services Research*, *16*1-9. doi:10.1186/s12913-016-1714-x.

Greenwood, M., & Heninger, J. (2010). Structured communication for patient safety in emergency medical services: A legal case report. *Prehospital Emergency Care*, *14*(3), 345 - 348. http://dx.doi.org/10.3109/10903121003760788.

Gregory, S., Tan, D., Tilrico, M. (2014). Bedside shift reports: What does the evidence say? *Journal of Nursing Administration 44*(10), 541 - 545.

Griffin, T. (2010). Bringing change-of-shift report to the bedside: A patient- and family-centered approach. *The Journal of Perinatal & Neonatal Nursing*, *24*(4), 348 -

353.

Grimshaw, J., Hatch, D., Willard, M., & Abraham, S. (2016). A qualitative study of the change-of-shift report at the patients' bedside. *Health Care Manager*, *35*(4), 294-304. doi:10.1097/HCM.0000000000000125.

Guide to patient and family engagement in hospital quality and safety. (2014). Retrieved from http://www.ahrq.gov/professionals/systems/hospital/ /index.html

Hagman, J., Oman, K., Klefner, C., Johnson, E., & Nordhagen, J. (2013). Lessons learned from the implementation of a bedside handoff model. *Journal of Nursing Administration*, *43*(6), 315-317.

Haider, S. (2009). The organizational knowledge iceberg: An empirical investigation. *Knowledge & Process Management*, *16*(2), 74 - 87.

Halm, M. A. (2013). Nursing handoffs: ensuring safe passage for patients. *American Journal Of Critical Care*, *22*(2), 158-162. doi:10.4037/ajcc2013454.

Healthcare Financial Management. (2012). Humanizing health care to boost patient satisfaction. Retrieved from http://www.hfma.org/Leadership/E-Bulletins/2013/May/Humanizing_Health_Care_to_Boost_Patient_Satisfaction/

Herbst, A. M., Friesen, M. A., & Speroni, K. G. (2013). Caring, connecting, and communicating: Reflections on developing a patient-centered bedside handoff. *International Journal for Human Caring*, *17*, 16 - 22.

Hospital Consumer Assessment of Healthcare Providers and Systems. (2012). Survey Instruments. Retrieved from http://www.hcahpsonline.org/surveyinstrument.aspx

Hospital Consumer Assessment of Healthcare Providers and Systems. (2013). Hospital Consumer Assessment of Healthcare Providers and Systems. Retrieved from http://www.hcahpsonline.org/home.aspxHoward, K. P., & Becker, C. A. (2016). Moving change-of-shift report to the bedside for UAP. Nursing 46(4), 14 - 16.

Johnson, C., Carta, T., & Throndson, K. (2015,). Communicate with me: Information exchanges between nurses. *Canadian Nurse*, *111*(2), 24 - 27.

Joint Commission Center for Transforming Healthcare. (2014). Hand-off communications. http://www.centerfortransforminghealthcare.org/ projects/detail.aspx?Project=1

Kassean, H. K., & Jagoo, Z. B. (2005). Managing change in the nursing handover from traditional to bedside handover – a case project from Mauritius. *BioMed Central*, *4*(1). 1-6/

Kitson, A. L., Muntlin-Athlin, A., Elliot, J., & Cant, M. L. (2014). What's my line? A narrative review and synthesis of the literature on Registered Nurse's communication behaviours between shifts. *Journal of Advanced Nursing*, *70*(6), 1228 - 1242.

Kleier, J. (2013). Disarming the patient through therapeutic communication. *Urologic Nursing*, *33*(3), 110 - 133. http://dx.doi.org/10.7257/1053-816X.2013.33.3.110.

Klim, S., Kelly, A., Kerr, D., Wood, S., & McCann, T. (2013). Developing a framework for nursing handover in the emergency department: an individualized and systematic approach. *Journal Of Clinical Nursing*, *22*(15/16), 2233-2243. doi:10.1111/jocn.12274.

Lane-Fall, M. B., Beidas, R. S., Pacual, J. L., Collard, M. L., Peifer, H. G., Chaves, T. J., ... Barg, F. K. (2014). Handoffs and transitions in critical care (HATRICC): Protocol for a mixed methods study of operating room to intensive care unit handoffs. *BioMed Central*, *14*(96), 1 - 24.

Lane-Fall, M. B., Speck, R. M., Ibrahim, S. A., Shea, J. A., McCunn, M., & Bosk, C. L. (2014). Are attendings different? Intensivists explain their handoff ideals, perceptions, and practices. *Annals of the American Thoracic Society*, *11*(3), 360-366.

Laws, D., & Amato, S. (2010). Incorporating bedside reporting into change-of-shift report. *The Official Journal of the Association of Rehabilitation Nurses*, *35*(2), 70–74.

Lupieri, G., Creatti, C., & Palese, A. (2016). Cardio-thoracic surgical patients' experience on bedside nursing handovers: Findings from a qualitative study. *Intensive & Critical Care Nursing, 35*, 28-37. doi:http://dx.doi.org/10.1016/j.iccn.2015.12.001.

Manchester, J., Gray-Miceli, D. L., Metcalf, J. A., Paolini, C. A., Napier, A. H., Coogle, C. L., & Owens, M. G. (2014). Facilitating Lewin's change model with collaborative evaluation in promoting evidence based practices of health professionals. *Evaluation and Program Planning*, *47*, 82 - 90.

Manning, M. (2006). Improving clinical communication through structured conversation. *2010*, *24*(5), 268 - 271.

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

to-nurse handoff promotes patient safety. *MEDSURG Nursing*, *21*(3), 140-145.

McMurray, A., Chaboyer, W., Wallis, M., & Fetherston, C. (2010). Implementing bedside handover: Strategies for change management. *Journal of Clinical Nursing*, *19*, 2580–2589.

Menefee, K. S. (2014). The Menefee Model for patient-focused interdisciplinary team collaboration. *Journal of Nursing Administration*, *44*(11), 598 - 605.

Midland Memorial Hospital. (2009). *Pathway to Excellence Application* [Annual report]. Midland, TX: Midland Memorial Hospital.

Midland Memorial Hospital. (2013). About us. Retrieved from http://www.midland-memorial.com/about-us/default.aspx

Milton, C. L. (2008). Accountability in nursing: Reflecting on ethical codes and professional standards of nursing practice from a global perspective. *Nursing Science Quarterly*, *21*(4), 300 - 303. http://dx.doi.org/10.1177/0894318408324314.

Ofori-Atta, J., Binienda, M., & Chalupka, S. (2015). Bedside shift report: Implications for patient safety and quality of care. *Nursing, 45*(8), 1 - 4.

Olson- Sitki, K., Weitzel, T., & Glisson, D. (2013). Freezing the process: Implementing bedside report. *Nursing Management, (44)*7, 25 -28.

Olvera, L., & Campbell- Bliss, M. (2011). Perfecting the patient handoff: Improving the process for patients and nurses. *Nursing for Women's Health*, *14*(6), 496 - 504.

Parush, A., Kramer, C., Foster-hunt, T., Mcmullan, A., & Momtahan, K. (2014). Exploring similarities and differences in teamwork across diverse healthcare

contexts using communication analysis. *Cognition, Technology & Work,16*(1), 47-57. doi:http://dx.doi.org/10.1007/s10111-012-0242-7.

Peter, E., & Liaschenko, J. (2003). Whose morality is it anyway? Thoughts on the work of Margaret Urban Walker. *Nursing Philosophy*, *4*(3), 259 - 262.

Pinkerton, S. (2008). The Unit Practice Council: center of professional practice. *Nursing Economics*, *26*(6), 401 - 403.

Pentland, D., Forsyth, K., Maciver, D., Walsh, M., Murray, R., Irvine, L., & Sikora, S. (2011). Key characteristics of knowledge transfer and exchange in healthcare: Integrative literature review. *Journal of Advanced Nursing*, *67*(7), 1408 - 1425.

Petrovic, M. A., Aboumatar, H., Scholl, A. T., Gill, R. S., Krenzischek, D. A., Camp, M. S., . . . Martinez, E. A. (2015). The perioperative handoff protocol: Evaluating impacts on handoff defects and provider satisfaction in adult perianesthesia care units. *Journal of Clinical Anesthesia, 27*(2), 111-119. doi:http://dx.doi.org/10.1016/j.jclinane.2014.09.007.

Radtke, K. (2013). Improving patient satisfaction with nursing communication using bedside shift report. *Clinical Nurse Specialist: The Journal For Advanced Nursing Practice*, *27*(1), 19-25. doi:10.1097/NUR.0b013e3182777011.

Riesenberg, L. A., Leitzsch, J., & Cunningham, M. (2010). Nursing hand-offs: A systematic review of the literature. *American Journal of Nursing*, *110*(4), 24-34. http://dx.doi.org/10.1097/01.NAJ.0000370154.79857.0.

Robins, Holly-May, CRNA,D.N.A.P., M.B.A., & Dai, Feng,M.S., PhD. (2015). Handoffs in the postoperative anesthesia care unit: Use of a checklist for transfer of

care. *AANA Journal, 83*(4), 264-268,234. Retrieved from http://search.proquest.com.ezp.waldenulibrary.org/docview/1711506689?accountid=14872

Salani, D. (2015). Implementation of shift report at the bedside to promote patient- and family-centered care in a pediatric critical care unit. *Journal for Nurses in Professional Development. 31*(2), 81-86.

San-Jecklin, K., & Sherman, J. (2014). A quantitative assessment of patient and nurse outcomes of bedside nursing report implementation. *Journal of Clinical Nursing*, *23*, 2854 - 2863

Scovell, S. (2010). Role of the nurse-to-nurse handover in patient care. *Nursing Standard*, *24*(20), 35-39.

Sherman, J., Sand-Jecklin, K., & Johnson, J. (2013). Investigating bedside nursing report: A synthesis of the literature. *MEDSURG Nursing*, *22*(5), 308 - 318.

Spaulding, A. C., Gamm, L. D., & Griffith, J. M. (2010). Studer unplugged: Identifying underlying managerial concepts. *Hospital Topics*, *88*(1), 1 - 9. http://dx.doi.org/10.1080/00185860903534125

Stagger, N., & Blaz, J. W. (2013). Research on nursing handoffs for medical and surgical settings: An integrative review. *Journal of Advanced Nursing*, *69*(2), 247 - 262.

Studer, Q. (2003). *Hardwiring Excellence: Purpose, Worthwhile Work, Making a Difference* (1st ed.). Gulf Breeze, Fl: Fire Starter Publishing.

Studer, Q., Robinson, B. C., & Cook, K. (2010). *The HCAHPS Handbook: Hardwire Your Hospital for Pay-for-Performance Success*. Gulf Breeze, Fl: Fire Starter

Publishing.

Studer, Q. (2014, June 3, 2014). Making process improvement 'stick'. *Healthcare Financial Management Association*, 1 - 6.

Studer Group. (2013). Key words at key times/AIDET. Retrieved from https://www.studergroup.com/what-we-do/institutes/upcoming-institutes/taking-you-and-your-organization-to-the-next-level/taking-you-and-your-organization-to-the-next-l-%282%29/tyyo-post-event-page/temp_tools/key-words-at-key-times-aidet/

Tan, A. K. (2015). Emphasizing caring components in nurse-patient-nurse bedside reporting. *International Journal of Caring Sciences, 8*(1), 188-193.

Taylor, J. S. (2015). Improving patient safety and satisfaction with standardized bedside handoff and walking rounds. *Clinical Journal Of Oncology Nursing*, *19*(4), 414-416. doi:10.1188/15.CJON.414-416

Thomas, L., & Donohue-Porter, P. (2012). Blending evidence and innovation. *Journal of Nursing Care Quality*, *27*(2), 116 - 124. http://dx.doi.org/10.1097/NCQ.0b013e318241cb3b

Thomas, M. J., Schultz, T. J., Hannaford, N., & Runciman, W. (2013). Failures in transition: Learning from incidents relating to clinical handover in acute care. *Journal for Healthcare Quality*, *35*(3), 49 - 56.

Thompson-Moore, N., & Liebl, M. (2012). Health care system vulnerabilities: Understanding the root causes of patient harm. *American Journal Of Health-System Pharmacy*, *69*(5), 431 - 436. http://dx.doi.org/10.2146/ajhp110299.

Timonen, L., & Sihvonen, M. (2000). Patient participation in bedside reporting on surgical wards. *Journal of Clinical Nursing*, *9*(4), 542 - 548. http://dx.doi.org/10.1046/j.1365-2702.2000.00400.x.

Trochim, W. M. K. (2006). Concept Mapping. Retrieved from http://www.socialresearchmethods.net/kb/conmap.php

Vines, M. M., Dupler, A. E., Van Sorn, C. R., & Guido, G. W. (2014). Improving client and nurse satisfaction through the utilization of bedside report. *Journal for Nurses in Professional Development*, *30*(4), 166 - 173.

Weaver, S. J., Lubomski, L. H., Wilson, R. F., Pfoh, E. R., Martinez, K. A., & Dy, S. M. (2013). Promoting a culture of safety as a patient safety strategy: a systematic review. *Annals of Internal Medicine*, *158*(5), 369 - 374. http://dx.doi.org/10.7326/0003-4819-158-5-201303051-00002.

Weeks, W., & Weinstein, J. (2014). Value creation strategies for health care. *Healthcare Financial Management: Journal of the Healthcare Financial Management Association*, *68*(1), 112 - 113.

Wolosin, R., Ayala, L., & Fulton, B. R. (2012). Nursing care, inpatient satisfaction, and Value-Based Purchasing. *The Journal of Nursing Administration*, *42*(6), 321 - 325.

Appendix A: Beside Handoff Synthesis Matrix

Author/Date	Nurse to Nurse Communication	Nurse to Patient Communication	Nurse to Interdisciplinary Team Communication	Patient Care Outcomes
Agency for Healthcare Research and Quality (2013b)	Prevents adverse events and errors Improved communication between nurses.	Patient engagement in care. Engages the patient's family in care	Safe transition between disciplines	Accountability Patient Safety Patient engagement
Alvarado et al. (2006)	Nurse to nurse communication improves with bedside report. Improves plan of care	Patient can engage in communication about his or her care	Recommend encouraging other disciplines to use bedside report	Patient safety Improved continuity of patient care information Accountability
Anderso & Mangino (2006)	Builds relationship between nurses Supports accountability, and communication Reduction of staff overtime including unlicensed personnel Accountability between shifts improves. Increases nurse satisfaction.	Increases patient satisfaction. Builds patient trust in healthcare providers. Reduces anxiety	Increases interdisciplinary teamwork. Reduces cost of patient care Increases healthcare team satisfaction	Patient-centered care Improves communication Patient safety Accountability
AORN (2012)	Structured communication is required Hand-off should occur during shift change and breaks	Patient safety	Handoff should occur for of all care providers/teams, and between institutions Interdisciplinary hand off should occur	Responsibility, accountability, and authority Patient safety
Baker (2010)	Prevents adverse events and errors Improved communication between nurses Builds teamwork and accountability More time to care for patients	Patient safety Builds patient trust in healthcare team Contributes to patient engagement Reduces patient anxiety Increase patient satisfaction with care	Builds interdisciplinary teamwork	Patient-centered care Patient safety Patient engagement Accountability

Benson et al. (2007)	Improves nurse communication	Positive patient outcomes	Improves interdisciplinary communication	Communication Patient safety
Bluni (2009)	Creates a partnership between nurse and patient Reduces pressure ulcers and fall rates	Supports patient education.	Suggests interdisciplinary rounding	Reduces harm to patients Increases positive outcomes for CMS clinical care domains Increases patient safety
Bradley & Mott (2013)	Nurse-to-nurse communication improves with bedside report. Improves plan of care	Increases patient satisfaction Builds patient trust in healthcare providers Reduces anxiety	Builds staff communication	Patient safety Improved continuity of patient care information
Brown & Sims (2014)	Improved communication between nurses Builds teamwork and accountability	Patient engagement in care Engages the patient's family in car	X	Patient safety
Bruton, et al., (2016)	Nurse to nurse communication improves with bedside report.	Patient engagement in care Engages the patient's family in care	X	Patient safety. Improved continuity of patient care information
Cairns et al. (2013)	Use standardized communication to improve handoff. Reduces end of shift overtime	Patient and family engagement		Increased patient satisfaction Decreased call light usage
Caruso (2007).	Improves nurse and patient relationship Improves communication between nurses and patients	Increased patient sense of security. Patient empowerment. Patient involvement. Patient is also a source of information.	**X**	Patient safety Patient-centered care
Chapman et al. (2016)	Improved communication between nurses Builds teamwork and accountability	Patient has the opportunity to engage in communication about his or her care.	Safe transition between disciplines	Patient-centered care Patient safety
Chin et al. (2011)	Reduces the gap in knowledge about patient and care plan	Patient perceived a positive view of teamwork, safety,	**X**	Patient safety Patient satisfaction

		quality of care.		
Cornell et al., (2014)	Improved communication between nurses	Patient safety	Recommend encouraging other disciplines to use standardized communication	Patient safety
Dufault et al., (2010)	Improved communication between nurses.	Builds patient trust in healthcare team Patient engagement	Builds staff communication	Patient-centered care Patient safety Patient engagement
Evans et al., (2012)	Use standardized communication to improve handoff. Reduces end of shift overtime. Increases nursing satisfaction.	Increases patient satisfaction. Builds patient trust in healthcare providers.	Improves interdisciplinary communication.	Patient-centered care. Improves communication.
Friesen et al., (2013)	Prevents adverse events and errors. Improved communication between nurses. Builds teamwork and accountability	Patient safety. Builds patient trust in healthcare team. Patient engagement.	Builds interdisciplinary teamwork.	Patient-centered care Patient safety. Patient engagement.
Gregory et al. (2014)	Accountability. Increased patient satisfaction. Nursing satisfaction. Increases team work and reporting.	Patient-centered care. Increased patient safety. Patient and family engagement. Improves patient adherence to care plan.	Builds staff communication. Increases staff communication about patient care and care plans. Contributes to interdisciplinary teamwork.	Improved patient centered care.
Griffin (2010)	Improves communication between nurses. An opportunity for nursing and patient education. Mentoring opportunity for new nurses.	Patient engagement. Patient satisfaction. Improves patient adherence to care plan. Engages patient family engagement.	**X**	Responsibility. Accountability. Patient safety. Continuity of care. Patient- centered.
Grimshaw et al. (2016)	Improved communication between nurses. Improves communication, reduces error when the patient is most vulnerable. Reduces the gap in knowledge about patient and care	Improves communication between nurses and patients. Increases patient satisfaction. Builds patient trust in healthcare providers.	X	X

	plan.			
Hagman et al. (2013)	Improved communication between nurses. Improves nurse and patient relationship. Improves communication between nurses and patients	Patient empowerment Patient involvement	Builds staff communication	Patient-centered care Patient safety Patient engagement
Halm (2013)	Prevents adverse events and error Improved communication between nurses Builds teamwork and accountability Structured communication is required Hand-off should occur during shift change and breaks	Increases patient satisfaction Builds patient trust in healthcare providers	Safe transition between disciplines	Patient-centered care and safety improves
Herbst et al. (2013)	Improves communication. Reduces error. Application of EBP.	Patient-centered care.	Increases staff communication about patient care and care plans.	Patient-centered.
Herbst et al. (2013)	Use a standardized tool for communication Ties to the Watson theory of Caring Builds relationship between nurses Supports accountability, and communication	Patient empowerment Patient involvement Increases patient satisfaction Builds patient trust in healthcare providers	Increases interdisciplinary teamwork	Patient-centered care and safety improves
Howard & Becker (2016)	Evidence-based practice. Use of SBAR to standardize communication.	Improves patient satisfaction with care.	Builds staff communication.	Builds patient trust in healthcare providers. Patient-centered care, Patient safety. Patient engagement.
Johnson et al. (2015)	Builds teamwork and accountability Nurse to nurse communication improves with bedside report Use standardized communication to improve handoff	Builds patient trust in healthcare providers	X	Increases patient safety and improves continuity of care

Kassean & Jagoo (2005)	Implemented bedside report/hand off to improve nurse to nurse communication and nurse to physician communication.	Implemented bedside report/hand off to improve patient satisfaction with care.	Implemented bedside report/hand off to improve physician satisfaction with nurses.	Patient safety
Klim et al. (2013)	Improved communication between nurses and floor units	Patient engagement	X	Patient-centered care Patient safety
Lane-Fall et al. (2014)	Increases nurse satisfaction Improves communication Reduces error Patient-centered care	Patient-centered care Patient safety Patient and family engagement	Improved staff communication	Patient safety Patient-centered
Laws & Amato (2010)	Standardized communication improves the efficiency and consistency of hand off.	Increases patient participation in plan of care Increases patient satisfaction	Contributes to interdisciplinary teamwork	Patient safety Responsibility Accountability
Manning (2006)	Use a standardized tool for communication Improves communication, reduces error when the patient is most vulnerable Improves nursing satisfaction. Bedside report is a skill that must be learned.	Benefits are patient engagement which might lead to improved adherences to care plan. Consider culture. Improves patient satisfaction with care.	Improves physician satisfaction Contributes to financial savings	Patient- centered Accountability Responsibility Patient safety
Maxson et al. (2012)	Improved communication between nurses. Builds teamwork and accountability	Increases patient satisfaction. Engages the patient's family in care.	Builds staff communication.	Patient-centered care and safety improves.
McMurray, et al. (2010)	Supports accountability and communication. Supports continuity of care. Bedside report is EBP. Ethical practice. Accountability. Bedside report is a skill that must be learned.	Patient- centered care Improves patient satisfaction Improves patient safety	Should be use for all transfers from inter-professional, inter-department, and outside patient care agencies.	Patient-centered care, communicating Accountability Patient safety
Ofori-Atta et al. (2015)	Bedside report saves lives. Improved	Increases patient satisfaction.	Increases interdisciplinary	Patient-centered care. Improves

	continuity of care. Reduces errors. Improves performance measurements. Improves communication between nurse and patient and other healthcare teams. Handover report for breaks should be done at the bedside.	Builds patient trust in healthcare providers. Increases patient engagement.	teamwork. Reduces cost of patient care	communication Patient safety
Olson-Sitki et al. (2013)	Prevents adverse events and errors Improved communication between nurses Builds teamwork and accountability Improves plan of care Use a standardized tool for communication.	Increases patient satisfaction	Builds staff communication	Patient safety Improved continuity of patient care information
Olvera & Campbell-Bliss (2011)	Use standardized communication to improve handoff	X	X	Patient safety
Radtke (2013)	Increases nurse satisfaction Improves communication Reduces error Patient-centered care	Patient-centered care Patient safety Patient and family engagement	Improved staff communication	Patient-centered
Riesenberg, Leitzsch, & Cunningham (2010)	Standardized communication reduces variability which reduces errors.	**X**	**X**	Patient safety Patient- centered
Salani (2015)	Supports accountability, and communication. Reduces the gap in knowledge about patient and care plan. Application of EBP.	Increases patient participation in plan of care. Increases patient satisfaction.	Contributes to interdisciplinary teamwork. Increases team collaboration. Increases healthcare team communication.	Reduces harm to patients. Increases positive outcomes for CMS clinical care domains. Increases patient safety.
San Jecklin & Sherman (2014)	Nursing satisfaction. Increases team work and reporting Accountability Increase patient satisfaction	Patient-centered care Patient safety Patient and family engagement	Improved communication overall	Patient safety Patient-centered
Scovell (2010)	Improved continuity	Improve patient	**X**	Patient safety.

	of care. Reduces errors Improves performance measurements Improves communication between nurse and patient and other healthcare teams Handover report for breaks should be done at the bedside.	safety		Accountability
Sherman, et al. (2013)	Nursing satisfaction. Increases team work and reporting. Accountability. Reduces overtime. Shortens report time.	Possible improvements to patient satisfaction. Increases patient engagement. Decreases falls and length of stay. Improves nurse and patient relationship.	**X**	Patient-centered care, communicating. Patient safety Accountability
Stagger & Blaz (2012)	Use standardized communication to improve handoff. Improves communication.	Patient- centered.	Improves communication.	Patient safety
Taylor (2015)	Use standardized communication to improve handoff. Improved continuity of care. Reduces errors. Improves performance measurements.	Increases patient satisfaction. Patient engagement. Improves patient adherence to care plan.	Contributes to interdisciplinary teamwork.	Patient-centered care. Patient safety
Thomas & Donohue-Porter (2012)	Increases nurse satisfaction. Improves communication. Reduces error. Application of EBP. Patient hand-off is a skill that is learned. Team building process.	Increases patient satisfactions. Engages patient in plan of care. Reduces patient falls and saves money. Reduces call lights care.	Increases team collaboration. Increases healthcare team communication.	Patient safety Accountability
Timonen & Sihvonen (2000)	Nurses obtain a better report.	Increases patient satisfaction. Patient engagement.	**X**	Patient-centered Patient safety.
Vines et al.(2014)	Builds teamwork and accountability. Nurse	Increased patient sense of security.	Builds interdisciplinary	Patient safety

	to nurse communication improves with bedside report. Improves plan of care.	Patient empowerment. Builds patient trust in healthcare providers.	teamwork.

X – no discussion

Appendix B: Charter Components

Project Name	The suggested name will be chosen by the committee. Eunice Rosas (DNP lead) made suggestions that will tie-in the name with the goal.
Leaders	The leaders will be the chair from the nursing discipline. The co-chair will be a non-nursing council member. Eunice Rosas will continue as the subject matter expert.
Sponsors	The sponsors for every shared governance council and committee are the executive level council members and all of the leaders of the other shared governance councils.
Team Members	The team members are the members of this committee. The team members are listed by job title or office held within the organization. The accountability is tied to the job title or office instead of naming an individual. This addresses organizational turnover.
Background	The problem statement of this project will provide a succinct description of issue to be addressed by this committee. For example; communication between nursing and ancillary departments is a broken process. The one is not communicating to the other important patient information. This lack of communication is leading to delayed patient care, orders not being verified or missed, and medications not being omitted or not given in a timely manner.
Objectives	The objectives of this project are the objectives listed within the charter.
Assumptions	The assumptions include membership requirements of the committee. This may include meeting attendance, participation, and fulfilling a leadership role within a unit. Financial assumptions are included in this section.
Constraints	Financial constraints are included in this section. The CNO, and COO are the ones that will approve any financial expenditures of

	this project. Major risks to this project, if any, will be identified within this section.
Deliverables	Deliverables are a policy and practice guidelines as delineated within the DNP project. The policy and practice guidelines will be submitted for validation to scholars. A long term plan for implementation and evaluation is included in this section.
Measure of success	The measure of success will be identified by the committee. For example a change in patient falls, reduction in codes, or reduction in community acquired infections.

Note. This committee charter is based on the Six Sigma principles. Go Lean Six Sigma. (2016a). Project Charter. Retrieved from https://goleansixsigma.com/project-charter/

Go Lean Six Sigma. (2016b). Six Sigma Project Charter. Retrieved from https://www.isixsigma.com/tools-templates/project-charter/six-sigma-project-charter/

Go Lean Six Sigma. (2016c). Project Template. Retrieved from https://www.isixsigma.com/images/stories/migrated/downloads/charter.pdf?bb3c77.

Appendix C: Policy

POLICY TITLE: BEDSIDE REPORT

PURPOSE: To standardize communication between nurses and interdisciplinary team members in order to increase the effectiveness and quality of patient hand-off. To increase patient engagement and involvement in his or her care plan.

DEFINITIONS: Bedside transfer of accountability report: A three to five minute report discussing a patient's care using the I PASS the BATON mnemonics at the bedside.

GUIDELINES: All healthcare providers will hand-off patients at the bedside using I PASS the BATON. Situations that call for report to be given away from the patient's bedside such as extremely sensitive issues are considered exceptions to the guidelines.

REFERENCES: Agency for Healthcare Research and Quality. (2013). Strategy 3: Nurse bedside shift report. Retrieved from http://www.ahrq.gov/professionals/systems /hospital/engagingfamilies/strategy3/index.html.

Appendix D: AHRQ Nursing Hand-off Guidelines

Upon admission:

Give the patient and family a copy of the bedside report brochure.
Ask patient to name a family member that is allowed to participate in bedside report.
Ask the patient if he or she has any questions.

Prior to end of shift:

Remind the patient and family that bedside report will occur within a specific time.

At the bedside:

Identify patient according to hospital policy.
Follow the AHRQ checklist.
Check pain score, discuss pain management and update pain board.
Identify any specific that needs to occur in the next 12 hours.
Identify any questions that the primary provider should answer prior to moving on the next patient.

Interdisciplinary Hand-off

Nurse to allied health

_____Confirm patient ID, orders for procedure
_____Communicate code status, allergies, O2 needs
_____Review limitations (bed rest, limited ROM).
_____Are there any specific patient education needs?

Allied health to nurse

_____Confirm patient ID
_____Review type of procedure and review new orders if any
_____Review limitations (bed rest, limited ROM).
_____Are there any specific patient education needs?

References

Agency for Healthcare Research and Quality. (2013). Strategy 3: Nurse bedside shift report. Retrieved from

http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy3/index.html.

Appendix E: Implementation Plan

Department				
Week Ending	Activity	Agenda	Attendees	Implementation Team
First week of implementation plan	Unit based council (UBC) meeting as scheduled by the UBC chair. Unit member of the Professional Practice Council.	Rationale for bedside handoff. Review I PASS the Baton Request frontline department champions/experts. from both day shift and night shift.	All front line team members.	VP of service line. Professional practice council chair. Clinical manager. Front line members of all shared governance councils. Department educator.
Third week of implementation plan.	Release policy, guidelines, and online training course.	Begin online training.	All department team members.	Executive level team member with access to all hospital systems.
Third week of implementation plan.	In-service - by frontline team champions and a member of the Professional Practice Council.	Review the policy, guidelines, and online training course. Review the implementation plan.	All department team members.	Educator and clinical manager to follow up.
Fourth week of implementation plan.	Begin bed-side report.	Implementation plan.	All department team members.	Educator, clinical manager, and shift team leaders to follow up.
Fifth week,	Department	Practice	Executive,	VP of service

sixth week, eight week, and every month.	rounds during shift change.	guidelines.	educator, and department leader rounds during implementation.	line. Clinical managers.
One year after implementation	Begin evaluation.	Compare pre-implementation data to post implementation data.	Executives, educator, and department leaders.	VP of service line. Clinical managers. Team leaders. Educator. COO, CEO, CNO.

Appendix F: Evaluation Plan - Frontline Staff

Week Ending	Activity	Goal (as set by committee)	Lead team member(s)
Six months prior to implementation	Begin to gather information. Create baselines per each department including interdisciplinary departments. The following components will be tracked: nursing communication, doctor communication, overall hospital rating, and recommendation of the hospital. The increases will be reported in percentages and in either a green or red color highlight.	Identify baselines for nursing communication, doctor communication, overall hospital rating, and recommendation of the hospital	Professional Practice Council chair, VP of service line, department UBC chair.
Six months prior to implementation	After baselines have been identified, each nurse manager and department members will set goals for each component and level using a simple report.	Departments to set goals based on baselines.	Professional Practice Council chair, department UBC chair.
Six months after implementation	Each department to begin to review and report patient satisfaction scores. Departments with the greatest increase will be identified. Departments with no increase or decline will provide a quality improvement plan with due dates and set goals.	Departments to begin reporting changes to department associates.	Professional Practice Council chair, department UBC chair.
One year after implementation	Begin to share pre-implementation and post implementation data during UBC	UBC chair to provide monthly updates. Each department is to	Department UBC chair and department

	meetings and leadership rounds.	identify a method to share the data to all team members.	champions
Every quarter after the 12 month period	Continue to share pre-implementation and post implementation data during UBC meetings and leadership rounds.	UBC chair to provide monthly updates.	Department UBC chair and department champions
Every quarter after the 12 month period	Round with all department team members. Share data. Celebrate wins.	UBC chair to provide monthly updates.	Professional Practice Council chair, VP of service line, clinical manager, CNO, department UBC chair.

Appendix G: Evaluation Plan - Executive Staff

Week Ending	Activity	Goal (as set by nurse manager)	Lead team member(s)
Six months prior to implementation	Begin to gather information. Create baselines per each department including interdisciplinary departments. The following components will be tracked: nursing communication, doctor communication, overall hospital rating, and recommendation of the hospital.	Identify baselines for nursing communication, doctor communication, overall hospital rating, and recommendation of the hospital.	Professional Practice Council chair, VP of service line, department UBC chair.
Six months prior to implementation	After baselines have been identified, each nurse manager and department members will set goals for each component and level.	Departments to set goals based on baselines.	Professional Practice Council chair, department UBC chair.
Six months after implementation	Each department to begin to review and report patient satisfaction scores. Departments with the greatest increase will be identified. Departments with no	Departments to begin reporting changes to department associates.	Professional Practice Council chair, department UBC chair.

	increase or decline will provide a quality improvement plan with due dates and set goals.		
One year after implementation	Begin to share pre-implementation and post implementation data during UBC meetings and leadership rounds.	UBC chair to provide monthly updates. Each department is to identify a method to share the data to all team members.	Department UBC chair and department champions
Every quarter after the 12 month period	Continue to share pre-implementation and post implementation data during UBC meetings and leadership rounds.	UBC chair to provide monthly updates.	Department UBC chair and department champions
Every quarter after the 12 month period	Round with all department team members. Share data. Celebrate wins.	UBC chair to provide monthly updates.	Professional Practice Council chair, VP of service line, clinical manager, CNO, department UBC chair.

Appendix H: Timeline of tasks and deliverables

- Present proposal to professional practice council.

  Create a committee
- Conduct the iceberg exercise. Identify obstacles Create a shared vision.
- Create charter
- Create policy and practice guidelines.
- Submit policy and practice guidelines to identified content experts.
- Revise charter, policy and practice guidelines based on content validation and expert feedback.
- The DNP and committee chair will schedule a date to submit the final products to the professional practice council. This ends the DNP role in the project.

http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/fundamentals/module8/exiceberg.html

NAppendix G: **Institutional Review Board (IRB) Record Number**

The Institutional Review Board (IRB) record number is 05-19-16-0125231.