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Nurse-To-Nurse End of Shift Report

Winifred N. Nzeribe
Walden University

Walden Universi

College of Health Sciences

This is to certify that the doctoral study by

Winifred Nzeribe

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

Review Committee
Dr. Amelia Nichols, Committee Chairperson, Nursing Faculty
Dr. Donna Bailey, Committee Member, Nursing Faculty
Dr. Phyllis Morgan, University Reviewer, Nursing Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2017

Abstract

Implementing Nurse-To-Nurse End of Shift Bedside Report

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Winifred Nzeribe

MSN/MBA, University of Phoenix, 2012

BSN, University of Maryland, 2001

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Handing over patient care at the end of a shift is a complex part of nursing practice that is commonly fraught with challenges. Ineffective communication continues to be the leading cause of sentinel events in the hospital setting. In response to this practice problem, this project involved the implementation of a standardized bedside reporting protocol in a surgical unit in line with the best available evidence. The overarching goal of this project was to determine how an end of shift reporting tool would impact communication, involvement of patient in care provision, and continuity of care at the bedside. The protocol was implemented in 2016, and involved the use of pre-test and post-test surveys to determine its effectiveness. The quasi-experimental project was guided by the Lewin's change theory concepts including unfreezing, change, and refreezing. An analysis of the findings of the survey revealed improvement in bedside reporting practices. The nurses had strong and positive perceptions of the program in improving communication, promoting patient safety, upholding nurse accountability, and promoting involvement of patient. There is a need for future projects to determine the impact of the program in improving patient satisfaction in various care settings. The positive social change of the current project results from improving bedside reporting practices to provide safe and patient-centered care in the health care agency.

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Dedication

This project is dedicated to the memory of my beloved late father Nze W. G. Ossai; and to my ever supportive family whose trust and believe in me helped me survive graduate school.

Acknowledgments

I wish to thank my God Almighty for HIS grace, love and compassion. My acknowledgement also goes to my wonderful and ever supportive husband Sir Viktor Nwedo Nzeribe, my children, Osora Nzeribe and Ebube Nzeribe; my mother and my siblings whose continued encouragement and support pulled me through graduate school. I wish to acknowledge my project committee, especially Dr. Amelia Ann Nichols and Dr. Donna Bailey; whose constructive criticism brought this Dissertation to completion. I cannot finish without saying thank you to my preceptors Angela Horton, and Rita Abiamiri whose support and mentorship will ever be cherished.

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Section 1: Overview of the Evidence-Based Project

Introduction

Handing over patient care at the end of shift is an intricate part of nursing care, which requires nurses to use effective communication to transfer patient information from an off-going nurse to the on-coming nurse. During the handover, responsibility and accountability are transferred to the oncoming nurse who continues patient care from where the other nurse stopped. The quality of nursing care a patient receives during a shift, to an extent, is usually dependent on the effectiveness of communication between nurses (Bluoin, 2011).

End of shift reporting occurs when the off-going nurse gives a report of the patient's situation, background, assessment, and recommendation (SBAR) to the on-coming nurse. The information transferred should include the care the patient received from providers during the previous shift. It also includes information about the care provided to the patient before that particular shift, the effect of care, and the plan of care moving forward. The essence is to promote patient safety, and support quality nurse practice (Caruso, 2007). According to Haig, Sutton, and Whittington (2006), a nurse who receives incomplete information at the beginning of the shift is unprepared for the delivery of quality patient care.

The communication between the nurse completing a shift and the one starting a shift is called hand-off, hand-over, end of shift report, report, and shift report. However, for the purpose of consistency, hand-off or end of shift report will be used in this paper.

To provide a systematic and uniform way of providing end of shift reporting, the SBAR reporting tool can be used. The SBAR tool enables the off-going nurse to write a report on a patient in a systematic way for accurate and complete provision of end of shift reporting data, improving effective communication. The Joint Commission on the National Patient Safety Goals (2007) mandated health care facilities use a standardized way of communicating at the end of shift.

Often, on Unit 3b (a medical surgical unit in a community hospital in Maryland) nurses call other nurses on previous shifts to clarify issues concerning the care they provided to patients during their shifts. Other nurses just assume they understood what they heard during an end of shift report while others simply continue with whatever they have to do to complete their shift. Sometimes, the off-going nurse may give report to the oncoming charge nurse because the oncoming nurse responsible for a patient will be late. When the late nurse arrives, the charge nurse will report the patient's information back to the oncoming nurse. The transfer of information can cause loss of pertinent patient information that may improve quality patient care. However, a few years ago, the manager on Unit 3b introduced bedside reporting using the SBAR reporting tool to his nursing staff. This change in practice was never made formal nor was it properly implemented. After four to six weeks, some nurses went back to the old ways of delivering end of shift reports, thereby creating an end-of-shift reporting process that was not uniform.

Miscommunication among nurses can cause adverse patient outcomes, similar to medication errors that decrease the safety and satisfaction of patients with the care provided. According to the Institute of Medicine's report (2000), 44,000 and 98,000 people die in the United States hospitals every year from avoidable errors (Institute of Medicine, 2000). Change of shift report is essential to the nursing care environment where nurses change shifts every eight or twelve hours.

The importance of effective communication among nurses during shift change cannot be over emphasized as it ensures quality care in a clinical practice arena (Chaboyer et al., 2010). According to Wakefield, Ragan, Brandt, and Tregnago (2012), reporting at the bedside allows patients and family involvement, increases teamwork among nurses, boosts accountability and improves effective communication between nurses and patients. Using the SBAR tool ensures a standardized reporting process that allows the inclusion of all the critical information in a patient's plan of care to be addressed and conveyed to the nurse coming on duty.

Problem Statement

Nurse end of shift reporting on a medical surgical unit must aim to improve efficient communication between nurses, increase patient participation, and enhance continuity of care (Chaboyer et. al., 2010). For patient safety and error minimization, the nurse-to-nurse shift report should be provided at the bedside using a hand-off tool for standardization (Joint Commission, 2007). According to Baker (2010), a report provided by the Institute of Medicine stated that 44,000 to 98,000 people die in the United States

hospitals every year from avoidable errors that can be eliminated with practice of bedside reporting using SBAR. Thus, the problem addressed was the implementation of a standardized end of shift handoff communication in a setting that uses a variety of informal handoff communication approaches.

Purpose Statement

The purpose of this project was to provide nurses with the information to increase effective communication and improve continuity of patient-centered care on a Medical Surgical Unit (3A) by providing end of shift report at the patient's bedside. Pretest/posttest and observation were used to measure participant's learning outcome. A pre and post-test questionnaire was used to determine the impact of the program on communication, perceived accountability of nurses, continuity of care, and involvement of the patients in the provision of care.

Project Objectives:

As a result of this project, the project leader:

1. Assessed the status of bedside reporting prior to an educational intervention,
2. Developed an educational intervention including a pre-test, post-test evaluation of participants,
3. Administered the educational intervention as part of a program project to improve bedside reporting,
4. Analyzed the data collected to determine the effectiveness of the program,

5. Communicated with unit and nursing leaders about the program evaluation for future planning, and
6. Communicated the findings from the program to relevant others (nurses, leaders, etc.) to add to our understanding of bedside handoff processes.

A Power Point Presentation and a YouTube video of nurses giving and receiving report at an unidentified bedside was used to educate VAMHCS 3A nurses on the techniques, and importance of bedside reporting using the SBAR hand-off tool. Additionally, a brochure that educates participants on the process of giving report at the bedside was distributed. The trainers demonstrated the process of bedside reporting using the SBAR, followed by a return demonstration by the participants.

Significance/Relevance to Practice

The implementation of a standardized SBAR tool and reporting at bedside improves communication among nurses and also increases patient involvement in their care and creates a smooth transition from one shift to another (Chaboyer, McMurry, & Wallis, 2010; Sand-Jeckin & Sherman, 2013). Bedside reporting ensures continuity of patient care and best practices in communication. The Joint Commission recommends that health care facilities use a standardized method to hand over patient information at shift change (Caruso, 2007). Therefore, an organization that adopts end of shift reporting at the bedside will be fulfilling this recommendation. According to Arora and Johnson (2006), The Joint Commission stressed the significance of using a standard method of handing off communication by including it as a National Patient Safety Goal in 2006. As

such, the Joint Commission evaluates handoff standardization as part of its accreditation requirement (Patterson & Wears, 2010).

Evidence exists indicating that end of shift report at the bedside using the SBAR script improves effective communication among nurses. Patient safety and decreased medication error in hospitals were also noted (Randmaa, Martensson, Swenne, & Engstrom, 2014). Bedside end of shift reporting has been implemented on the telemetry unit of a Maryland community hospital. However, my investigation revealed that, despite the implementation, nurses on the unit provide report standing in the hallways, at the nurse's station, in the classroom, or in the dictation room.

Shift reporting provided in this fashion can be chaotic. Patients' anxiety can increase when waiting to see his or her new shift's nurse and wondering if the nurse knows about his or her care plans (Dardess, 2013). Up to 66% of sentinel events in hospitals are caused by miscommunication (Sand-Jeckin & Sherman, 2012). The implementation of Nurse-to-Nurse End of Shift Report Using SBAR tool decreased all these negative effects on quality patient care. In addition, it fulfills the organization's goal of improved patient-centered care.

Project Question

How will an end of shift reporting at bedside improve effective communication and enhance continuity of care?

Evidence-based Significance of the Project

According to research, giving report at patient's bedside using the SBAR can improve communication among nurses, increase patient safety, and decrease medication errors in hospitals (Randmaa, et al. 2014). The use of the SBAR reporting tool was implemented on the Medical Surgical Units (3B) of this Maryland community hospital three to four years ago. However, the author's investigation revealed that despite the implementation, nurses on this unit use three different types of the SBAR Tool; lacking uniformity. Nurses on the unit provide the report to one another while standing in the hallways, and at the nurses' station. Shift reporting provided in this fashion can be chaotic. When everyone is talking at the same time, miscommunication is bound to occur, and this can cause errors in patient care that may result in an adverse patient outcome. The purpose of this project was to improve communication among nurses during a shift change using the SBAR tool, and increase continuity of patient care. Accurate transfer of relevant patient data and information, and a professional communication process that decreases noise at shift change, provides continuity of patient care, and fewer calls to off duty nurses for clarification of patient status.

Implications for Social Change in Practice

Although the implementation of the nurse bedside report may be clouded with many challenges, studies have shown that changes in practice can benefit the organization, nurses, patients and their families (Laws & Amato, 2010; Tan, 2015; Wakefield et al., 2012). The implementation of a standardized SBAR tool at end of shift

reporting at bedside will help the organization reach its goal of providing patient centered care (Laws & Amato, 2010). Shift reporting at bedside is essential to the communication between nurses and patients. This interaction is important to the positive hospital experience of the patient which promotes quick recovery and return to the patient's normal lives and roles before the injury or illness occurred. Social change is achieved when the patient returns to regular activities with family and society as it was prior to hospitalization.

Bedside report using SBAR is an excellent approach to respond to a number of the Joint Commission's National Patient Safety Goals (Baker, 2010). With the change in practice, nurse will have the opportunity to verify the report provided by visualizing the patient on the spot. In addition, the oncoming nurse can complete a baseline assessment on a patient as the report is being given. Immediate or early assessment will enable the nurse to plan and prioritize the tasks required to complete patient's care for the shift (Laws & Amato, 2010). Nurses will provide quality care if they know that another nurse will check what they done during their shift. For example, a nurse will remember to place date on IV tubing if the oncoming nurse will check for that during shift report (Baker, 2010).

Bedside reporting offers a smooth transition from one shift to another (Chaboyer et al., 2010). Nurses can develop meaningful teamwork and a sense of ownership with the bedside report implementation (Baker, 2010). Both WHO and the Joint Commission agreed and are calling on health care providers to encourage patients and their families to

increase participation in patient's care. With the implementation of nurse-to-nurse bedside report, nurses, patients and their families have the opportunity to exchange valuable information about the patient's healthcare plan (McCloskey, Furlong, & Hansen, 2012). Patients' anxiety will decrease if they trust that nurses know what they are doing and are capable of providing excellent care to them.

Definitions of Terms

Agency for Healthcare Research and Quality (AHRQ): An agency that works to improve outcome and quality healthcare (AHRQ, 2016)

Bedside shift report: the term is synonymous with several other terms including hand-off, change of shift, report, and shift report. Bedside report is a technique of exchanging patient related information in his or her presence, and providing them with an opportunity to be involved and ask questions (Griffin, 2010). During the hand-off practice, relevant information including the treatment plan and the patient condition is communicated from the outgoing nurse to the oncoming nurse (Griffin, 2010).

Center for Disease Control and Prevention (CDC): A United States Agency that tracks public health trends and diseases

Communication: The term communication, in this project, refers to the transfer of vital patient-related information from one nurse to another.

Health Insurance Portability and Privacy Act (HIPPA): Legislation that was developed to improve portability and continuity of the health insurance coverage for workers in the United States (U.S. Department of Labor, 2015).

Evidence-based practice: The integration of the best available clinical expertise, patient perspectives and preferences, and external scientific evidence to provide high quality care (Sackett et al., 2000).

Joint Commission: Formally called (JCAHO) Joint Commission on Accreditation of Health Care Organizations. It is a non-profit agency that works to protect patient safety and quality healthcare. They advocate for standardized healthcare by providing accreditation to healthcare organizations (Joint Commission, 2017).

Situation, background, assessment and recommendation (SBAR): A tool to improve communication among care provider by ensuring a standardized format to share information during bedside handoff (Cornell, Gervis, Yates, & Vardaman, 2013).

Assumptions

The assumption is nurses who completed the pretest stays on staff through implementation to the evaluation period. Individuals who completed the pretest were expected to also complete the posttest. Therefore, the assumption is that the same nurses would complete the pre and post tests for more accurate results. It was also assumed that patients would accept to be involved in the hand off. The incoming nurses could be late for work or the off going nurse may have had an emergency that warrant leaving the hospital before the end of shift. It could be assumed that the nurses would arrive to work on time to facilitate prompt reporting process or the off- going nurse stays to the time the oncoming nurse arrives.

Limitations

Reporting in a nonprivate room may pose a privacy problem. Nurses are supposed to adhere to HIPPA during the process of providing patient care. Patients may be too sick, weak, sleepy, or fatigued to participate during report and family may not be available.

Summary

Communication is important in transferring patient information between nurses at the change of shift because patient responsibility and accountability is transferred during a shift change. The quality of nursing care a patient receives during a shift, to an extent is usually dependent on the effectiveness of communication between nurses at shift change (Bluoin, 2011). Using a hand-off tool like the SBAR is necessary to standardize the handing off process (Patterson & Wears, 2010). Implementing the nurse end of shift bedside report using the SBAR tool enables an organization fulfill the recommendations of the Joint Commission on National Safety Goal (2007). Patients can develop trust for their nurses through effective communication that can take place during bedside report (Clevenger & Connelly, 2012). Not only will bedside reporting promote nurse to patient relationships, the novice nurse can learn from the communication and clinical assessment that takes place during the report (Baker & Mcgown, 2010).

Section 2: Review of Scholarly Evidence

Specific Literature

A literature review was conducted to study the various methods to report at bedside using SBAR handoff. Caruso (2007) used the Lewin's three stages of change to demonstrate how bedside reporting was successfully implemented in one hospital. Chaboyer et al. (2010) described how the perceived outcome of SBAR use improved accuracy, delivery of service and how patient-centered care was improved. Heinrichs et al. (2012) found the use of the SBAR reporting tool decreased the rate of adverse events and increased effective communication. The hospital employees preferred to practice with SBAR than with the Global Trigger, a tool they had been using.

Randman et al. (2014) used a prospective intervention study with a control group using pre assessments and post assessments during implementation of SBAR in an anesthetic clinic. Wakefield et al. (2012) reviewed the current process of shift reporting and existing patient satisfaction scores. The author identified obstacles and facilitators of transitioning to bedside shift reports. In a study completed by Clevenger and Connelly (2012), patients reported that with the implementation of bedside report, nurses communicated better, listened actively, and treated them with courtesy and respect. This made them perceive the nurses cared about them.

Theoretical Framework

Change Theory

Kurt Lewin's change theory was used to effect the desired change needed to solve the health care problem of ineffective communication between nurses during a change of shift report. Change theory requires that a prior learning be rejected and replaced by new one. The Change theory consists of three stages, unfreezing, change and refreezing.

1. Unfreezing: This process involves a method or methods of convincing individuals to let go of the old way of doing things that were not productive. It is important because it allows individuals to overcome their resistance that can give way to group conformity. Unfreezing occur when driving forces are increased, restraining forces decreased, or a blend of the two forces. The staff of unit 3A took their time to unfreeze, the process took a little longer than was expected, although these nurses were involved in the planning phase, during the first two weeks, it took the involvement of the nurse leaders and nurse manager to keep reminding staff to go to the bedside during report.
2. Change**:** The actual change in behavior, thoughts, feeling or a combination of the three. At this stage, the group has come to understand the reason for the change and is beginning to take ownership of the change. They hold each other accountable and responsible for their actions. They are committing and contributing to the change process. After two weeks into implementation,

nurses started taking actions without being reminded. The resistance displayed at the start of implementation reduced gradually.

3. Refreezing**:** This is the acceptance and adoption of the change as a behavior and the standard way of operation. The refreezing stage solidifies the new procedure and stops a relapse to the old ways. Kurt Lewin (2014) described three concepts*:* (a) *Driving forces*: forces that propel in the direction that will allow desired change to occur; (b) *Restraining forces*: forces that obstruct change; and (c) *Equilibrium*: the driving and restraining forces are equal providing zero change.

Pretest/Posttest Model

The single-group pretest/posttest method was used to evaluate the Nurse-to-Nurse Bedside Reporting Program. At the beginning of the planning stage, a pretest was completed to evaluate what the anticipated participants knew and what they had to say about end of shift report. At the end of the implementation, a post test was completed by the same participants who completed the pretest to evaluate if there was an improvement in patient involvement in the provision of care, and determine if there were improvements in communication among nurses.

Educators have used the pretest/posttest to monitor student's progression and learning throughout a course or program; administering a test of entry behavior or learning can determine whether assumed prerequisites to a course have been achieved.

The tests are useful for determining where skill and knowledge deficiencies exist and where they are most frequently developed (Boston University, 2014).

Section 3: Approach

Project Design/Methods

Implementing change in an organization can be challenging. Introducing a change in practice in a health care organization is not an easy task to accomplish. Individuals can resist change because they are comfortable with what they are familiar with and do not want to go outside their comfort zone to learn new practices. To help such individuals overcome their fear of the unknown, and for the project developer to succeed in implementation, shareholders need to be included in the project planning (Hodges & Videto, 2011).

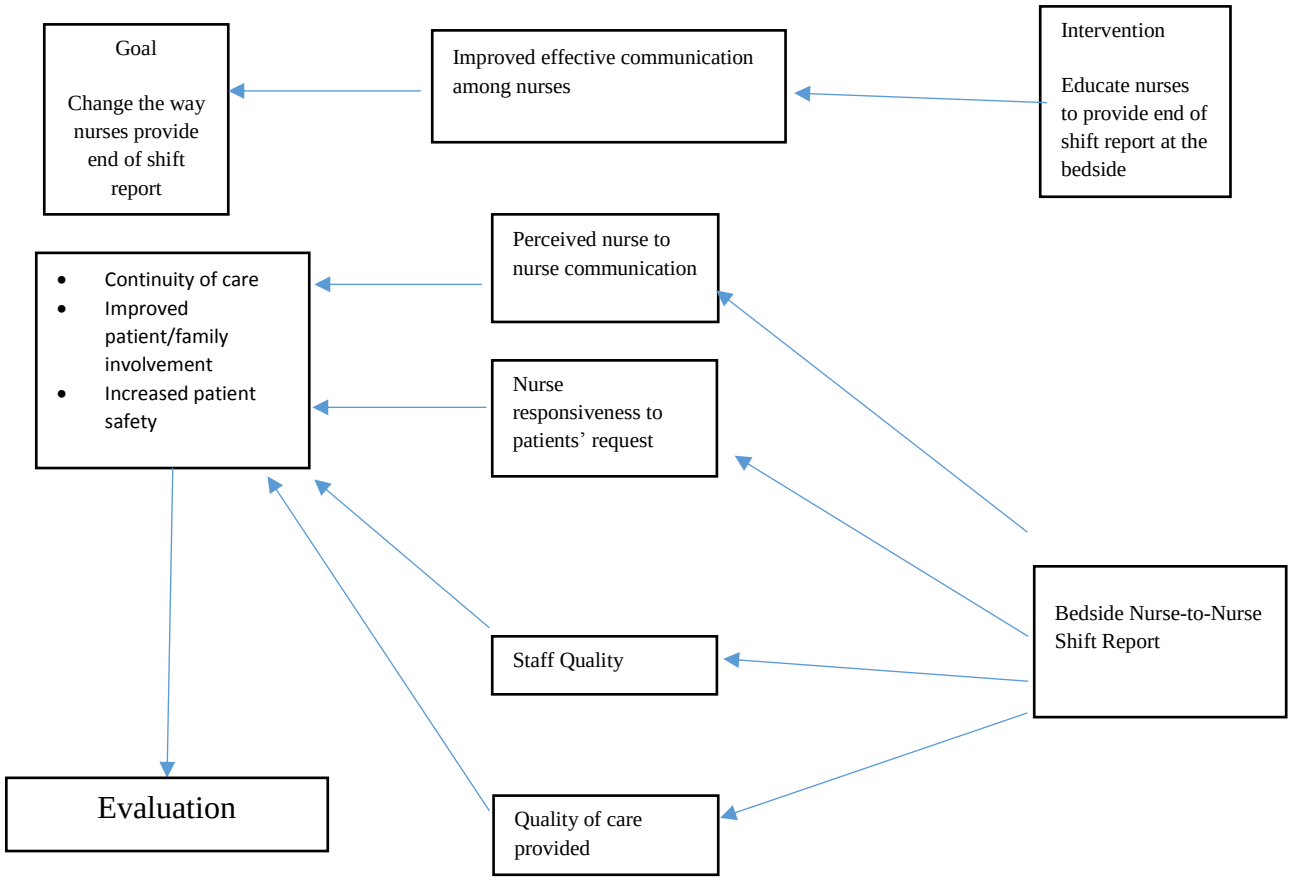
The inclusion process increases stakeholder's awareness and understanding of problems and challenges; it also produces additional information to help determine priorities, improve support for a remediation program, and largely advance probability of success. Target population processes offer a reality check for scientific efforts (CDC, 2001). Inclusion of members of the target populace can increase the credibility of outcomes. If stakeholders are not engaged in the processes, the evaluation will risk missing essential elements of the program. Evaluation results can be overlooked, criticized, or resisted because the target populations' concerns or inputs were not taken into consideration. Stakeholders are in a position of providing important inputs to the evaluation process, including reality checks on the suitability and practicability of the evaluation questions. These ideas can affect program implementation and evaluation. According to Compass, et al (2008), empowering stakeholders can inspire participation.

At the conception of any major project in this organization, the project manager or project leader must present a proposal to the organization's Nurse Practice Council (NPC) whose responsibility is to approve or disapprove the project. Approval is based on a majority vote of the Council members. Some of the members are nurse executives. The Education Committee approves the education portion of the program and assists in the provision of resources for educating and training staff. It is important to involve these stakeholders at the beginning of the planning process. The list included Unit 3A's nurse manager, their clinical nurse leader, the unit share governance council representatives. After meeting with the key people on the unit, a face-to-face meeting to introduce the project was held. Involving a small group of key people (charge nurses, some senior nurses) early in the discussions can help identify vital concerns, barriers, prospects, and resources necessary for the success of the planning (Melnyk & Fineout-Overholt, 2011).

During the planning process, additional target populations may be introduced as required to enhance the core group. Availability of time determined the number of meetings held by the population to discuss program activities and plans on how to move forward. The meetings helped in gaining a clear understanding of the group's interests, perception, and concerns in relation to the program. In addition, the stakeholders were able to identify and agree on their roles and responsibilities. The project leader also assured the participants that on open line of communication would be maintained to address their concerns (Hodges & Videto, 2011).

Strategies to navigate disagreement or lack of interest were keeping open, straightforward, and consistent communication with stakeholders by updating them on matters that relate to the program. Their ideas and opinions were also integrated in the project evaluation process. Challenges to the project were identified and addressed with immediate effect. Moreover, their expectations from the onset were addressed during the project development and implementation (CDC, 2001).

Figure 1: Program Design



Population and Sampling

The study was conducted on a Medical-Surgical unit in a community health care system in Baltimore, Maryland. The unit contained a total of 32 beds; 12 private beds, four semiprivate rooms, and 3 four-bed rooms. Patient admissions were through internal medicine and general surgery services. Twenty full time registered nurses provided care at the bedside. Forty percent of the nurses were BSN prepared while 60% were associate degree holders. All 20 registered nurses were given opportunity to participate in the study. Participation was voluntary, and nurses who did not wish to take part in this study were assured of no repercussions.

Data was collected through pretest questionnaires, and observations of the nurses. Prior to the training, the nurses completed questionnaires answering questions that determined their knowledge of end of shift reporting on their unit, their views on the current method of end of shift reporting, and their opinion of what was working well and what was not working quite well. Posttest questionnaires were completed six weeks after implementation of the bedside shift reporting to determine if the change in practice was worthy of adoption.

Program Budget

Improving nurse-to-nurse communication by implementing bedside reporting using SBAR (Situation, Background, Assessment, and Recommendation) tool was an inexpensive project. The majority of the expenses required to implement the project were fixed expenses the organization would normally make if this project did not exist. For

example, two staff from unit 3A were part of the implementation team. The Clinical Nurse Manager (CNL) of the unit was one of them. She did not accumulate any extra costs for taking part in this program. The others were 10 staff nurses who work nights and day shifts; extra costs were not incurred because of their participation in meetings. Meetings were held during regular working hours. There were no hires from outside 3A, therefore, no need for additional salary expenses. There were no expenses apportioned to space, electricity, telephones, and other equipment. Information was exchanged during staff meetings. Paper and printing costs were born by the researcher.

Cost-effectiveness analysis (CEA) is an appropriate financial method of analysis in bedside reporting. It is regarded as a financial assessment in which costs and consequences of substitute interventions are booked as a unit of health outcome. In this method of financial analysis, costs and consequences are compared as competing interventions for a particular patient or group in a particular budget (Phillips, 2009). Effective communication among nurses if not addressed, could bring about miscommunication that result in medical and medication error (IOM, 2000). Ineffective communication is generally accepted as a major cause of medical errors (Reisenberg, Leitzsch, & Cunningham, 2010). Nurses will become dissatisfied, decreased teamwork will suffice and retention problems will increase, which will end in low quality health care and adverse outcomes. Patients and families will become dissatisfied and may turn to other health care organizations for their health care needs. Cost-effectiveness analyses

recognize overlooked prospects by emphasizing interventions relatively less costly, and have the likelihood of reducing the problem burden significantly.

Cost-effectiveness analysis helps to recognize ways to distribute resources for improved outcomes. If the problem of miscommunication among nurses is not addressed, in the short term, medication and medical errors will increase, patient's safety jeopardized, Joint Commission recommendations neglected. The health care organization may be struggling with nurse retention as miscommunication can cause nurse dissatisfaction. When nurses are dissatisfied quality of care tend to decrease resulting in patients and family dissatisfaction. This may result in the loss of customers. Without customers, an organization cannot make money and will be forced to go out of business.

Cost-effectiveness analysis method is used for assessing the profits in health relative to the costs of other health interventions. It is one of the important criteria for making decision on how to distribute resources as it directly relates to the economic and logical consequences of different interventions. It offers information on the costs of improving health by means of a specific intervention (Jamison, Breman, & Measham, 2006). The funds put into the bedside reporting program should be considered monies well spent. The implementation of this project will improve effective communication among nurses and patients. Customers are given the opportunity to participate in their care - they can ask and answer questions during report which will boost their trust of their caregivers leading to improved patient satisfaction, compliance, and outcomes.

Data Analysis

The responses gathered from the survey were entered into an Excel workbook and the data imported into Statistical Package for Social Sciences (SPSS) version 21. The t test was used to determine whether any significant differences exist between the pre-test and post-test. The questions on the Likert-like scale survey assessed nurse knowledge of bedside shift report before and after implementation. Six weeks into project implementation, participants were observed providing report at the bedside.

Project Evaluation Plan

Program evaluation enabled the developer determine the impact of a program. To establish the cause and effect relationship, an impact assessment needs to be completed. The evaluation provided feedback on results to the planners about the effectiveness of program allowing the opportunity to make changes on what was not working well (Kettner, Moroney, & Martin, 2013). The single-group pre-test/post-test method was used for the Nurse-to-Nurse bedside reporting program. At the beginning of the planning stage, a pretest was completed to evaluate what the anticipated participants knew and what they have to say about the program. At the end of the implementation, a posttest was be completed by the same group that completed the pretest to evaluate if the program is heading the direction it was intended to.

Briefly, the posttest determined if change occurred. In addition, participants were observed during bedside reporting to monitor how the nurses conduct their end of shift reports. Educators have used the pretest/posttest to monitor student's progression and

learning throughout a course or program; administering a test of entry behavior or learning can determine whether assumed prerequisites to a course have been achieved. The tests were useful in determining where skill and knowledge deficiencies existed and where they are most frequently developed (Boston University, 2014). The data collected will be analyzed and results used to determine whether bedside reporting should be adopted. Barriers to evaluation include funding, time, and proper communication. To overcome these barriers, program planners need to meet with and obtain buy-in from the administration, and funding approval. Keeping open communication for effective collaboration with shareholders can improve participation.

Performance Measurement, Monitoring, and Evaluation

During this first meeting, the project planner used a pre-test questionnaire (Likert-like scale) type questions to evaluate participants. Participants were observed providing end of shift report prior to training to determine their knowledge and awareness of program. Other stakeholders like the nurse executives and nurse leaders were met separately to evaluate also their attitudes, concerns and willingness to approve the use of organization materials and time. According to the National Center for Injury Prevention and Control (2013), short-term, intermediate outcome evaluation measures participants' behaviors, knowledge, attitudes, and awareness of a program prior to intervention.

On December 7th, 2015 the long–term impact of the program was evaluated. Participants completed a posttest by answering the same exact questions they answered prior to training. The project manager, unit nurse manager, and unit clinical nurse leader

were appointed to observe bedside nurses provide report at the bedside using checklist. Direct observation was used because of its objectivity. Variables that needed attention were tasks completed by nurse, tools used, collaborators, and work location (Cornell, et al., 2013). After completing the checklist, they submitted them to the unit manager. The project developer collected the checklist from the unit nurse manager for entry into the excel spreadsheet. Results of the long-term outcome evaluation determined if the program improved nurses accountability, communication, and involvement of patients in the provision of care during the handoff. Most importantly, long-term outcome evaluation was used to determine if the study is worth adoption (McNamara, 1999).

Table 1: Program Evaluation Plan

Goal	Objectives	Activities
To evaluate the adoptability of the Nurse-to-Nurse Bedside End of Shift Reporting in a Medical Surgical Unit	Assess participants' attitudes and knowledge of bedside reports	Hold a meeting to introduce the program to participants. Administer a survey in form of questionnaire to determine participants' knowledge about bedside reporting, answer and questions they may have and alleviate their fears. Observe participants (nurses) give report at the end of shift and complete checklist.
	Evaluate the cost of implementing Bedside Shift Report	Hold a meeting with nursing administration to introduce the program; obtain approval and determine their financial commitment. Plan an implementation budget.
	Evaluate the effect of the changed attitude	Observe nurses provide shift reports at the bedside using checklist. Have nurses complete the same questionnaire they completed at the beginning of the program.

Summary

Program evaluation is an organized and scientific approach to measure a program design, implementation, and outcome. Using the pretest/posttest method enabled the developer to evaluate the short term and long term outcomes. It also helped the planner make adjustments as deficiencies were identified. Nurse bedside reporting process was monitored by observation. Data was collected at the time and place the process was occurring (CDC, 2008).

Section 4: Findings, Discussion, and Implications

Introduction

The overarching purpose of this DNP project was to implement a standardized shift handover protocol to enhance continuity of care and improve communication among bedside nurses. The first objective was assessing the status of bedside reporting three months prior to the formal implementation of the SBAR program. The second objective related to the development of the educational intervention including a pre-test, post-test evaluation of the participants. The third objective was implementing the program to improve bedside reporting. This was followed by analyzing the data collected to determine the effectiveness of the program. The last objective related to communicating with unit and nursing leaders about the program evaluation for future planning. The purpose of this section is to provide a summary and a discussion of the findings, and the implications of this project.

Profile of the Participants

There were seven women (70%) and three men (30%) who agreed to take part in the project. The mean age and the standard deviation of the nurses who participated in the project were 35 and 3.1 years. Most of the nurses had a baccalaureate degree in nursing with one of them having a master's degree (Table 1). All the participants were in rotational working shifts. With regards to work experience, the nurses had worked for an average of 15 years of experience. Although the participation in the project was on a voluntary basis, all the bedside nurses were required to take part in the training program,

but they could choose to complete the questionnaires or not for the current project. There were 20 bedside nurses at the time of the study, but only 10 were willing to complete the questionnaires. However, one of them did not complete the post-test questionnaire; thus the total number of the bedside nurses who provided informed consent and completed the survey was nine. Table 2 provides a summary of the descriptive statistics on the level of education for the nurses who took part in this project.

Table 2: Level of Education

Nurse Education	*Number*	*%*
License vocational nurse	2	20%
Associate degree	1	10%
Bachelor of science in nursing	6	60%
Master's degree in nursing	1	10%

Summary and Evaluation of the Findings

Pre and post-implementation surveys about perceptions of nurses to handoff practices at the bedside were completed. A five-point Likert scale requiring the participants to indicate to what extent they agreed with the various statements was used. The questionnaire requested the nurses to select statements ranging from strongly agree

(1), neutral (3), and strongly disagree (5). For the pretest, there was agreement that nurses did not prepare the patient on a regular basis prior to the shift (mean =2.1). Of the 10 nurses, only one agreed that nurses always prepared patients before the shift while the remaining nurses disagreed with the statement.

The implementation of the SBAR tool led to significant improvements. There was a substantial change in the mean scores between the pre (2.1) and post-test survey (mean= 4.6) (Figure 2). Six nurses strongly agreed that nurses were preparing the patients prior to the shift with the three remaining nurses agreeing moderately with the statement. The decrease toward the "disagree" end of response meant that more nurses were involving patients in the provision of care.

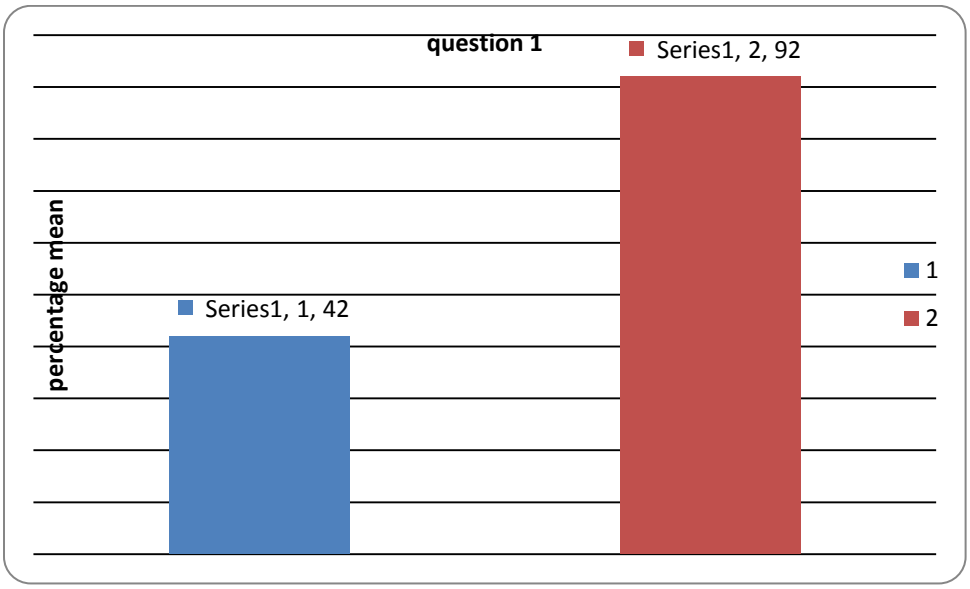


Figure 2: Question 1

For Question 2 (the off-going nurse introduces the oncoming nurse to the patient and at the beginning of shift report), all the nurses disagreed or strongly disagreed with the statement at the pre-implementation period (mean = 1.9). The findings of the post-implementation period indicated an improvement in bedside reporting practices with seven nurses agreeing that an off-going nurse introduces the oncoming nurse at the beginning of a shift (mean= 4.33) (Figure 3). The findings show that nurses were involving patients in the provision of care and were communicating effectively with each during shift transition.

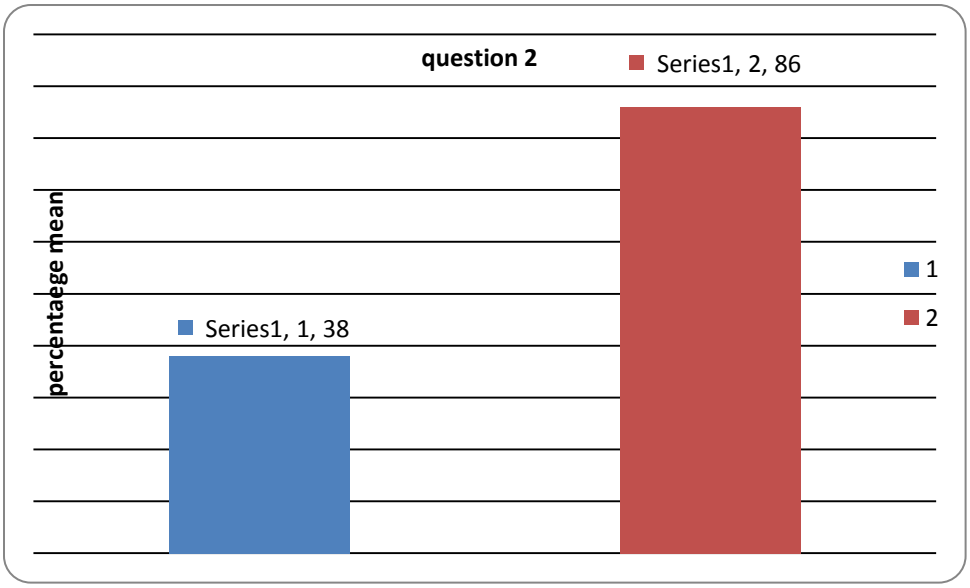


Figure 3: Question 2

For the third statement "On this unit, the incoming and off going nurse verify patient with at least two identifiers at the beginning of report," the pre-intervention percentage was 100% for strongly disagree while the post-intervention was 90% and 10%

for strongly agree and agree (Figure 4). The decrease towards the "strongly disagree" indicates that the project led to the improvement of patient safety by encouraging the nurses to verify patient details at the beginning of a shift.

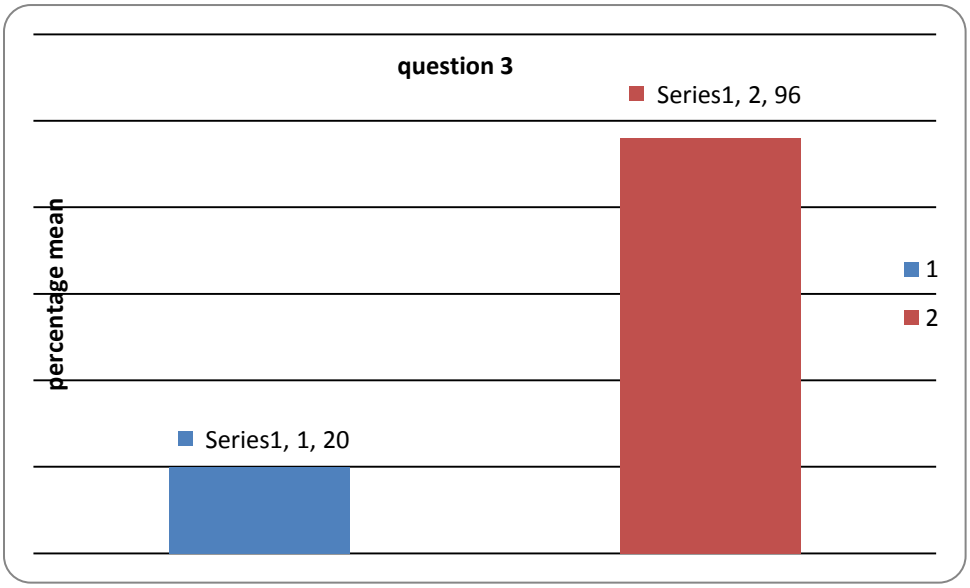


Figure 4: Question 3

With the statement "nurses ask patients for permission to provide report at bedside," the pre-intervention percentage for the strongly disagree statement was 100%. The finding shows that the nurses were not asking for consent thus the patient's right to self-determination may have been violated in some instances. The pre-implementation findings showed an improvement in the involvement of the patient in the process of care with 90% of the nurses strongly agreeing with the statement (Figure 4). An off-going nurse asking for permission from the patient is in line with HIPAA guidelines which

require patient privacy and the right to self-determination to be upheld all the time (CDC, 2003).

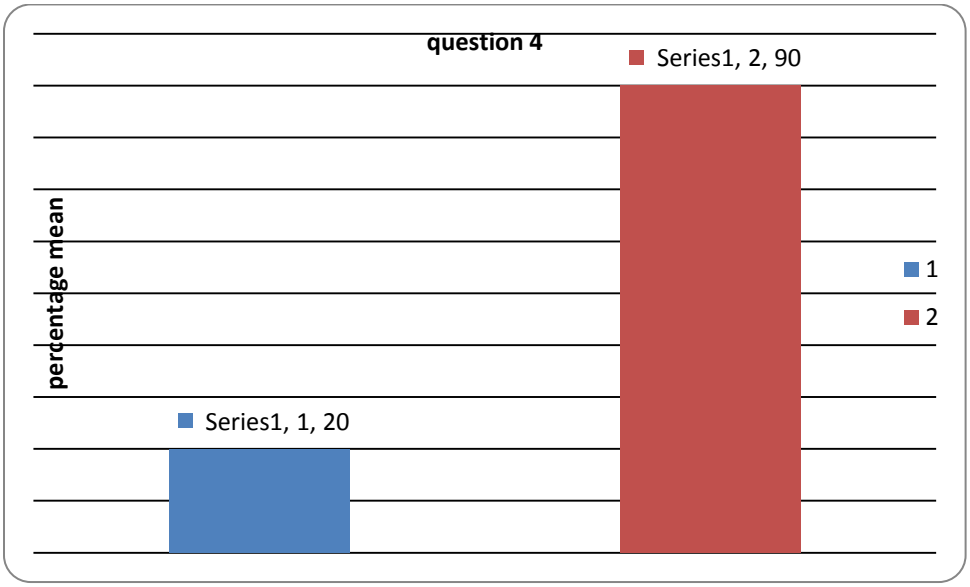


Figure 5: Question 4

Question 5 and 6 related to the use of the SBAR tool. For the statement "on this unit, nurses provide report using the SBAR tool," half of the nurses strongly agreed that the tool was being used at the bedside with one of them remaining neutral and two of them disagreeing with the statement (Figures 6 and 7). This was a clear indication that prior to the implementation of the current project, there was poor use of the standardized procedures in conducting bed shift reports. The post-implementation data showed a significant improvement in the transition of care with all the nurses who took part in the final survey strongly agreeing that the recommended practice was being followed. The use of this approach provides a framework for effective communication among the nurses

and creates an environment that allows the patients and the nurses to express their concerns.

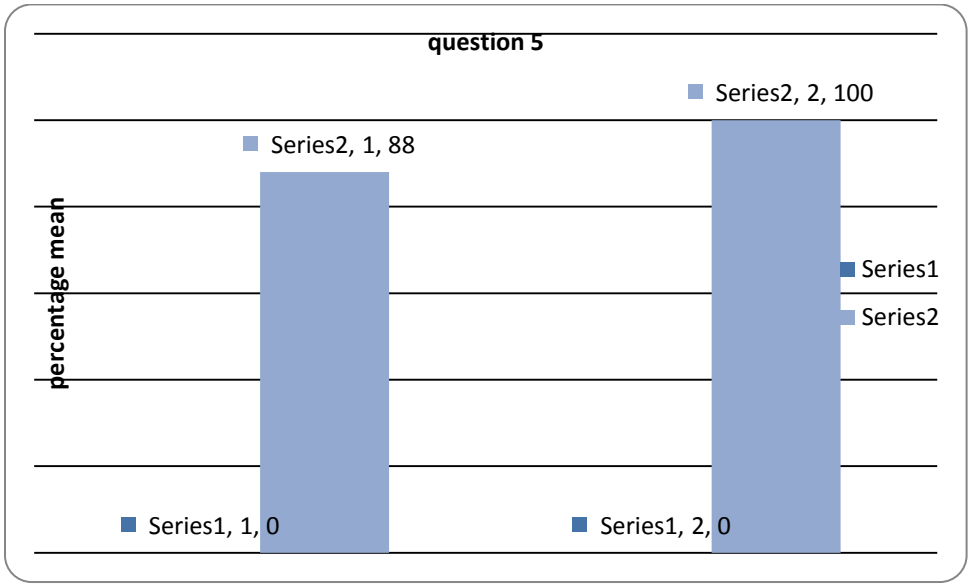


Figure 6: Question 5

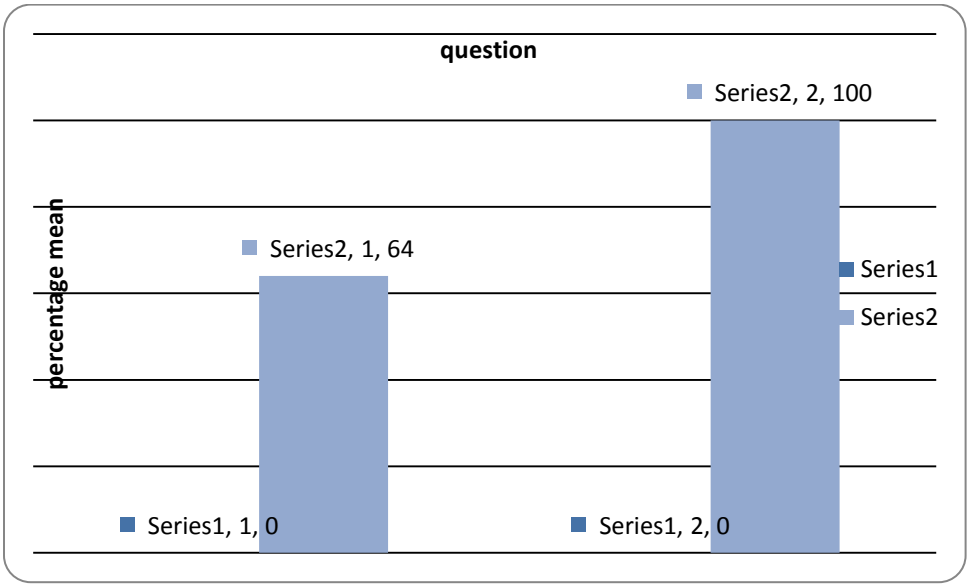


Figure 7: Question 6

Question 7 and 9 aimed at assessing how the bedside reporting system improved patient safety and accountability of the nurses. The pre-implementation percentage was 80% for disagree option and 90% for question 7 and 9 respectively. The post-implementation data showed improvements in the percentage of the nurses who agreed that care providers were assessing patient comforts in the transition of care. The post-implementation percentage was 100% for strongly agree and agree option (Figure 8 and 9).

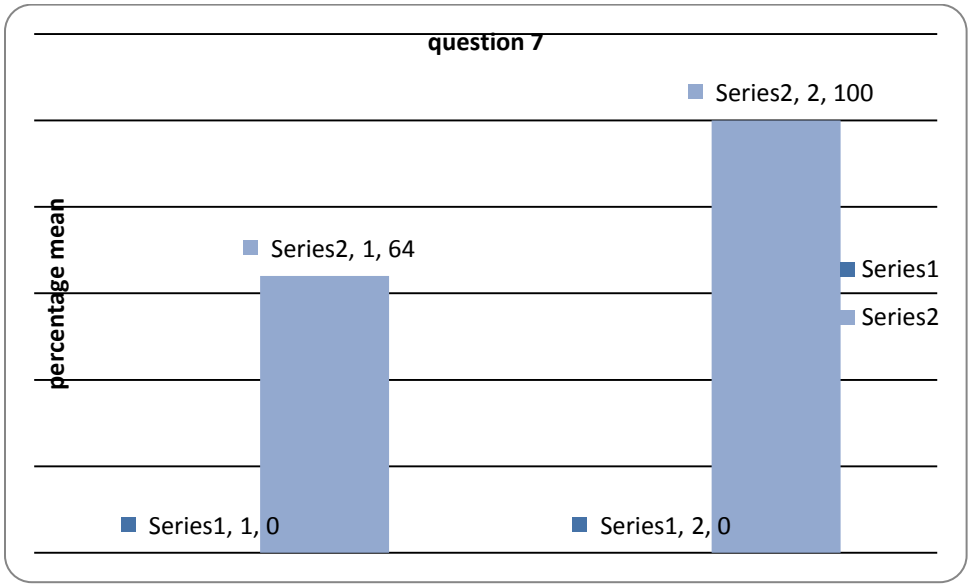


Figure 8: Question 7

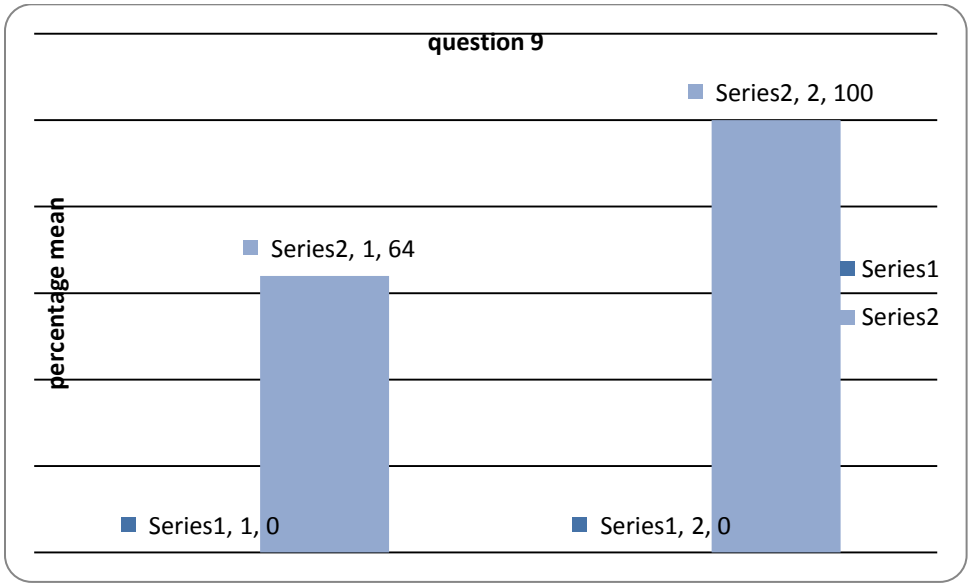


Figure 9: Question 9

In response question 8, all the nurses strongly agreed that equipment were not checked for proper functioning at the beginning of a shift (Figure 10). The post-

intervention results showed a change in practice with all the nine nurses who took part in the post-intervention survey strongly agreeing with the statement.

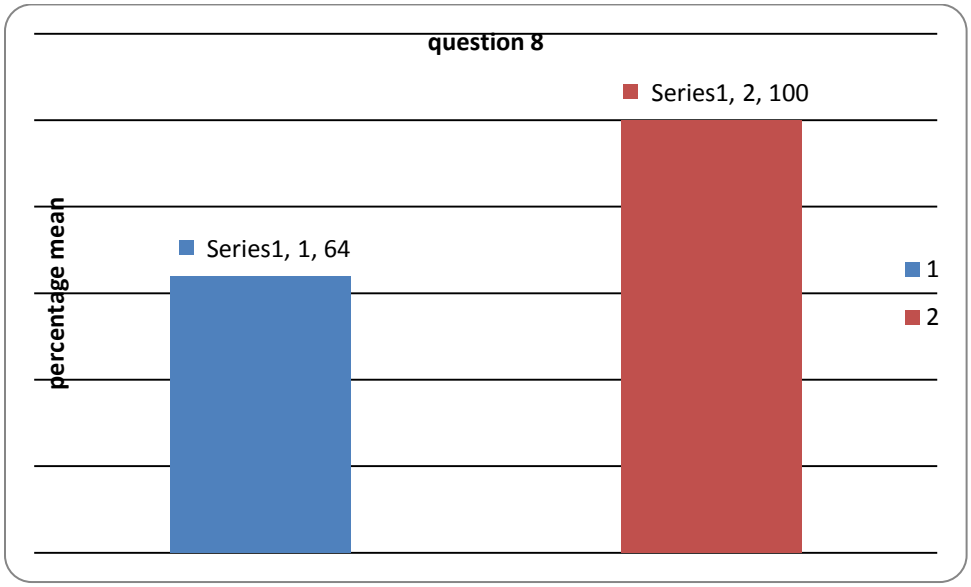


Figure 10: Question 8

For the last statement "3A nurses update the whiteboard during shift report", 50% of the participants disagreed with the statement with the remaining either agreeing or strongly disagreeing (Figure 11). The post-implementation data showed all of them strongly agreeing with the statement suggesting a change in attitude towards the role of nurses in filling out a whiteboard.

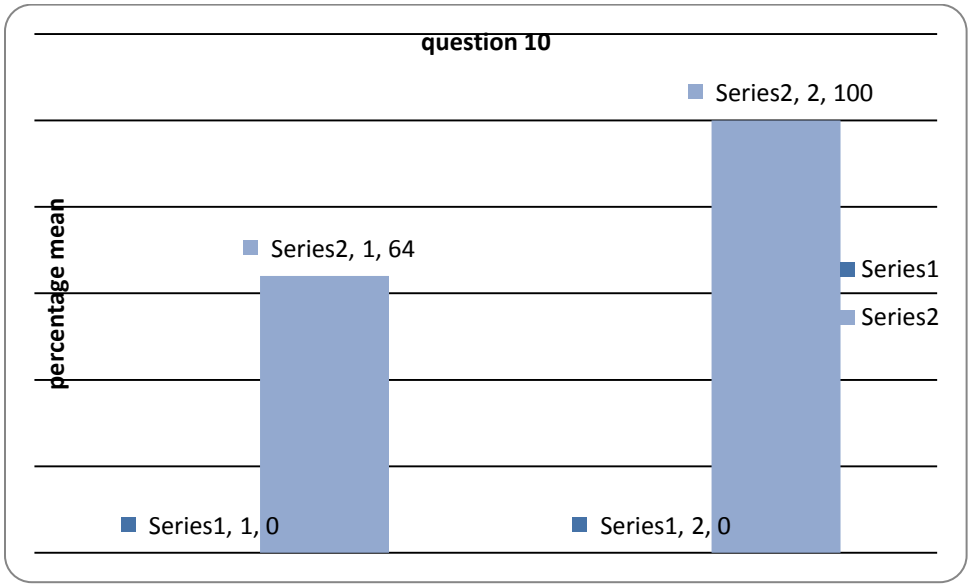


Figure 11: Question 10

An independent sample t-tests analysis of the results was carried out to determine if the changes were statistically significant. The statistical analysis showed that there were statistically significant improvements in the post-intervention scores ($t\ 14.4) = 1.76$, $p< 0.001$. The data is of importance because it concerns the safety of the patient and whether essential information is passed on to the oncoming nurse so as to provide holistic care. The findings indicate that the intervention provided led to improved use of the standardized hand-off reports leading to an improvement in communication, accountability, and continuity of care which are essential elements in the provision of safe patient care.

Discussion of Findings in the Context of Literature

To evaluate the differences between the pre and post-intervention with regards to bedside reporting practices, percentages were computed for each statement. The data for the bedside report shows an improvement in bedside reporting practices of the nurses after the intervention. Overall, there was an improvement in each aspect of bedside report practice with data for all the questions showing improved compliance with the recommended bedside shift reporting practices. This could be attributed to the provision of education during the implementation period.

The provision of education during the implementation period improved the use of standardized hand-off reports leading to improved engagement of patients in the provision of care. Consistent findings were reported by Rush (2012) who found that improved bedside reporting allowed patients to remain informed and involved in their care leading to increased satisfaction and reduced anxiety related to their ill-health. This is because bedside reporting allows the patient to meet the new nurse and provides an opportunity to establish the baseline assessment.

Improvements in communication were also noted. There were improvements in the use of the SBAR tool and more nurses are updating the whiteboard during shift transition. Implementation of SBAR has been associated with enhanced communication between care providers thus preventing negative patient outcomes and strengthening teamwork approach to the provision of care (Rush, 2012). This is because the tool provides common expectations such that will be communicated and how the

communication will be structured while focusing on the provision of care and not individual differences (Tan, 2015).

The SBAR technique also provides a way to hand-off relevant information in the presence of the patient, allowing active participation of the patient in his or her care. The patient is central to all information surrounding care activities. Patients can ask questions or add information to the discussion. Through this process, the patient sees the staff working as a team and is assured that all involved know and agree on the plan of care. Evidence suggests that better-informed patients are less anxious and more likely to follow medical advice (Tan, 2015).

The Joint Commission safety goals require hospitals to use standardized means of communication with regards to provision of care to patients (Caruso, 2007). The findings in the current study are consistent with those of Sand-Jecklin and Sherman (2013) who found bedside report led to substantial improvement in communication among nurses. The post-implementation survey also showed an improvement in the accountability of nurses. Consistent findings were reported by Laws and Amato (2010), Rush (2012), & Sand-Jecklin and Sherman (2013) who found that bedside reporting led to improved accountability of the nurses.

Theoretical Framework

The current project was supported by the Lewin's Three Stage Change Theory. The three steps include unfreezing, change, and freezing. The process of unfreezing in this project involved challenging and antagonizing the current attitudes and beliefs of the

nurses that were related to poor shift reporting practices. The project leader issued formal announcements and held face to face meetings with the head nurses to achieve the goal of unfreezing. These activities spurred informal discussions among the nurses and generated some anxiety. As a result, they began to look for more information and think about the benefits of the improved handoff practices. Consequently, a state of disequilibrium was reached and their resistance to change was overcome (Burnes, 2004).

The second step involved educating the nurses about the end of shift reporting at the bedside so as to improve communication, involvement of patients, and continuity of care. After two weeks of the implementation period, it was observed that nurses' shift handover skills improved and they began to take responsibility for their actions. The resistance displayed at the start of the implementation reduced gradually.

The third stage is refreezing where the change agent endeavors to sustain the adoption of the desirable behavior (Burnes, 2004). Some nurses became project champions and closely monitored the compliance with the new bedside reporting protocols. The peer to peer accountability helped the nurses in sustaining the change and prevented relapse to the old way of doing bedside reports. According to Lewin (2014), refreezing is a challenging stage of change management but it is essential for the long-term gains of an institution. The stage was accomplished successfully because the head nurses kept sharing the positive outcomes with the bedside nurses.

Implications

Implications for Practice

The findings of this project demonstrate that implementation of a standardized bedside reporting system leads to significant improvements in communication, nurse perceptions of accountability and involvement of patients leading to improved quality and safety of care provided. It is important for bedside nurses to have effective communication as much as possible during the transition process to maintain continuity of care and provide safe care to the patient (Sand-Jecklin and Sherman, 2013). Involving the patients and their family members in the nurse bed shift report gives them a chance to know what has already occurred during the shift and the subsequent steps in their care. It also provides them with an opportunity to have an input in the process of providing care (Friesen et al., 2013).

Due to the positive effects that were associated with the implementation of the standardized bed shift reporting system, the practice will be expanded to other care units in the hospital. Nurses from the other hospital units will be invited to take part in the implementation process and will be empowered by the project leader and nurse managers to identify and alleviate various obstacles that may hinder effective implementation of the program. It is also recommended that other health care organizations should implement similar programs. The findings of this project will be disseminated through various platforms once the research is ready for publications and will give hospitals wishing to adopt this program an idea of how to go about the implementation.

The findings reported in this project have implications for various stakeholders including bedside nurses, patients, and hospital administrators. It is recommended that nurses should always prepare the patient prior to the shift through adequate and effective communication. It is also important that bedside nurses communicate effectively with their colleagues so as to maintain continuity and provide safe care. Additionally, there is a need to continue reminding nursing staff about the importance of following the SBAR bedside reporting procedures as well as appreciating that it is a requirement in the health care facility. Implementation of a standardized bedside reporting system has been a focus of the Joint Commission. In an attempt to improve coordination of care, the organization recommends that there should be effective shift handoffs between the ongoing and incoming nurse through the provision of shift reports including all essential information about the plan for the provision of care to the patient in the next hours (Wakefield, Ragan, Brandt, & Tregnago, 2012). As new policies outlining how to improve the safety and the quality of care provided to patients continue to be developed, health care providers must be ready to adopt evidence-based practice to improve patient outcomes.

Implications for Future Research

There is a need for further research to establish the impact of this project on patient satisfaction levels. The current study only focused on the perceptions of nurses, and evaluating patient satisfaction levels as a result of the implementation of the standardized bed shift reporting system is an area that necessitates further research. On the other hand, there is an opportunity to evaluate the impact of a bed shift reporting

system on patient safety, improvements in communication, continuity of care, and patient engagement for various forms of handoff practices within diverse care units and organizational settings. Moreover, specific events that take place during shift changes could be investigated for their frequency and severity to have a better outlook of the impact of the program on the patient safety. Longitudinal research can also be carried out to determine if the effects of this program have remained over a longer period of time than the time interval in this study. The study can be used to carry out further analysis to establish which units have the lowest and the highest compliance rates.

Implications for Social Change

Social change involves changes in human behavior, norms as well as the structure and functioning of the society (King, 2014). This form of change particularly takes place in nursing when there is a modification of attitudes, outlooks, and assumptions. The current project has contributed to changing of nurses' attitudes and beliefs about shift report practices. Before the implementation of the program, nurses working with the care facility had a tendency of giving reports in the office or along the corridors.

There was a change in behavior with nurses shifting from a nurse-centered report to a patient-centered one which is standardized and completed at the bedside. The change in practice enabled patients and their family members to comprehend the plan of care and have an idea of what to expect (Griffin, 2010). This, in turn, lead to increased patient satisfaction with the care provided and had the potential to lessen the turnover costs leading to financial benefits to the hospital (Gregory et al., 2014; Laws, & Amato, 2010).

The implementation of the standardized bedside reporting system has also promoted positive social change in the care facility by promoting improvements in communication and continuity of care.

Strengths and Limitations of the Project

Strengths

The project had two main strengths. The first strength relates to the consistent support from the health care facility management during all the phases of the project implementation. There was a high level of commitment and engagement from the nurse managers, and this was a major reason for the success of the current project. The second strength relates to effective teamwork skills among the nurses who took part in this project. There was peer to peer support and encouragement which led to the success of the program.

Limitations

The project had several limitations. The first limitation relates to the number of the participants. A small sample size was used thus generalizability of the findings is questionable. There is a possibility that the nurses who took part in the surveys were not representative of the entire population of nurses within the hospital units. Moreover, one nurse did not complete the final survey leading to differences in the number of surveys completed prior to and after the intervention.

A second limitation of this project related to self-reporting of the nurses' practices. Self-reported data may be affected by the social desirability bias where the

participants try to provide desirable responses (Paulhus, & Vazire, 2007). Some nurses may have attempted to provide responses in a manner that would have been viewed favorably by the project leader. In addition, the self-report questionnaire may have been biased by the participant's feelings at the time of completing the questionnaires (Vazire & Mehl, 2008). For instance, negative responses may have been provided by the participants who may have been frustrated by events not related to the use of the standardized bed shift reporting system.

Another limitation at the hospital was maintaining the confidentiality of each patient while preparing the bed shift report. Violating the HIPPA policies relating to confidentiality of patients was a source of concern among the nurse. The nurses expressed apprehension with having to request visitors to leave the room even after obtaining consent from the patient. On the other hand, though the nurses were required to talk in low tones, the patients were not aware of this and could at times communicate in high tones. There is a need to discuss the HIPPA confidentiality guidelines in the work place so that the nurses can take reasonable precautions to avoid violating the policy.

Analysis of Self

The DNP program has enabled me to develop as a practitioner, scholar, and project developer. I became a registered nurse in 2002, and I have consistently maintained the highest level of knowledge, skills, and competence that is required in the process of providing holistic care to patients. The skills and the knowledge have been credited through the advancement of my nursing education over the past one decade. I

feel that my future as a nurse practitioner has been brightened by the acquisition of the critical analysis skills and the improved ability of applying theory to practice as well as translating evidence-based findings into practice. The knowledge and expertise developed during my DNP journey have facilitated my development as a nurse researcher. The basics of the DNP program is to enable graduate nurses develop, implement, and assess health outcomes in various settings (American Association of Colleges of Nursing, 2006; Chism, 2015). The DNP project inculcated critical analysis skills in developing and evaluating research aimed at improving the health of the population.

As a Practitioner

I have grown as a clinician, scholar and as an individual. The DNP program has impacted me with new knowledge and skills which will be of help in my new role as a doctorally prepared nurse. My specialty in nursing education requires me to advance my knowledge and skills as a nurse leader (Chism, 2015). I have learnt about various leadership roles in health care setting and applied evidence-based findings at the bedside leading to practice change. The implementation of this quality improvement initiative aimed at improving bedside shift report allowed me to put into practice the expertise acquired from the doctoral program. The use of the change theory is one example that guided the current project. I was able to apply the three steps of Lewin's Change Theory to introduce and implement change in the care facility. The three stages were important in addressing the negative perception of nurses, promoting the use of a standardized

reporting system, and refreezing the new state of affairs to prevent relapse to the old ways of doing bedside reports.

As a Scholar

Undertaking the DNP program has led to personal discoveries and allowed me to grow as a scholar. The DNP project gave me an opportunity as an advanced nurse to translate and integrate knowledge into clinical practice, which is a requirement for a doctoral prepared nurse (Zaccagnini & White, 2011). I have developed essential primary research skills during the process of implementing the project. I had a practical experience of administering surveys and carrying out both descriptive and inferential statistical analyses. The process of collecting and analyzing data made a significant contribution to my scholarly growth. I am now equipped with essential primary research skills and my self-confidence as a scholar has also improved significantly as a result of conducting the research. I will remain committed to scholarly growth through continuing education and taking part in nursing research so as to stay abreast in the contemporary nursing standards.

As a Project Manager

As a doctoral student, I wrapped up my education be implementing the bedside shift report to improve communication and continuity of care within the organization. The DNP program requires the candidate to identify a substantial practice problem based on their experience and interest, and apply the knowledge acquired through the program to address the problem. The implementation of the bedside reporting project provided me

with the first opportunity to investigate and deal with a problem in nursing. As I reflect on the phases involved in completing the project, I could simply admit that each aspect of the project took to a new but challenging experience.

Implementation of the project was a challenging task that called for a high level of commitment and required a tremendous amount of time the DNP candidate. I had to build strong relationships with various stakeholders so that the project could gain an appropriate level of buy-in to move forward. This experience gave me an opportunity to apply theory into practice to achieve the project goals. Grant (2012) states that leaders should have the ability to move their followers beyond their individual agendas to striving to realize team goals. The project faced some form of resistance at the beginning as the nurses were concerned about their workflow, but as the project leader as able to apply the Lewin's change theory to shift their focus to patient safety.

Future Professional Development

The DNP program has prepared me as an advanced nurse practitioner by advancing my skills and expertise in applying theory to practice and using evidence to address problems in the health care sector. I hope to continue in nursing leadership, laying emphasis on evidence-based techniques to address the current barriers to the provision of safe patient care. As a doctoral prepared nurse, I have acquired the knowledge, expertise, and competence required to promote positive practice change even in the most intricate health care environments (Zaccagnini & White, 2011). My future

goal includes becoming a nurse educator, taking part in policy development, and leading research in primary care settings.

Summary and Conclusions

Handing over patient care at the end of a shift is a complex part of nursing practice that is commonly fraught with challenges. Ineffective communication continues to be the leading cause of sentinel events in the hospital setting (Sand-Jeckin & Sherman, 2013). During the handover process, the responsibility and accountability of care are transferred to the on-coming nurse who continues care from where the other nurse stopped. The purpose of this project was investigating the potential effects of implementing a standardized bedside reporting system to improve communication and provision of care to patients.

A pre and post-test approach was used to implement and evaluate the effectiveness of the project. Surveys testing communication, accountability, continuity of care, and engagement of patients in the provision of care were administered before and after the implementation. The project was guided by the Lewin's change model which includes three main steps; unfreezing, change, and freezing. Support from the management and involvement of the stakeholders in good time were the main elements that led to the success of the project.

The implementation of the standardized bedside report was associated with improved communication among the nurses during shift changes. The use of a standardized reporting system has to been found to be effective because the exchange of

information during shifts prepared the oncoming nurse adequately to take care of the patient (Gregory et al., 2014; Laws, & Amato, 2010). Implementing the reporting system also led to more engagement of patient in the provision of care and this is in line with the Joint Commission recommendations for the provision of holistic and patient-centered care (Wakefield, Ragan, Brandt, & Tregnago, 2012).

While the level of patient satisfaction as a result of the new practice was not evaluated, future projects may show improvements in patient satisfaction. To determine the level of satisfaction, questions relating to patient satisfaction may be added to the tool used in this study or develop a better questionnaire to measure the outcomes. Nevertheless, health care facilities may decide to implement the SBAR tool considering that it improves communication, continuity of care, and involvement of the patient in the provision of care.

Section 5: Scholarly Dissemination

Dissemination of project findings is an essential and integral part of the DNP program. The DNP program has given me an opportunity to implement and assess an evidence-based program related to bed shift reporting practices by nurses. It is imperative that holders of doctoral degrees are able to disseminate research findings to health care professionals and other stakeholders in the health care sector. The dissemination of scholarly findings means sharing the outcomes of the project so that innovations leading to improved patient safety can be applied to similar settings (Oermann & Hays, 2015).

Dissemination of findings provides the researchers with an opportunity to share their successes as well as challenges they encountered in the research process. Zaccagnini and White (2011) provide two main reasons for dissemination of DNP scholarly findings. The first purpose is to share the results with the academic community and the stakeholders. The second purpose is sharing the findings with practitioners who are providing care in similar settings. The findings of this project will be disseminated through both internal and external approaches. The findings will be disseminated orally to essential stakeholders during an internal meeting and in the organization's quarterly News Letter.

The project leader also hopes to share the findings through online publication. It is essential that a researcher is able to critically analyze and decide an appropriate journal depending on his or her needs and the target audience (Oermann, 2012). I hope to publicize my finding in the ProQuest Journal as recommended by Walden University.

Science, which is a peer review journal focused on improving the safety of care provided to patients. The findings will be available free of charge due to the open view policy thus have the potential to promote adoption of standardized bedside reporting practices. I feel that the dissemination of the findings of this project is critical to the process of quality improvement in the nursing practice; hence, it is essential to promote free access to scholarly findings.

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