2017

Bedside Reporting: Improving Practice

Lori Wichman
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Lori Wichman

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Mary Verklan, Committee Chairperson, Nursing Faculty
Dr. Mirella Brooks, Committee Member, Nursing Faculty
Dr. Jeannie Garber, University Reviewer, Nursing Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2017

Abstract

Bedside Reporting: Improving Practice

by

Lori C. Wichman

MSN, Walden University, 2013

BSN, California State University, Sacramento, 2003

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

December 2017

Abstract

Bedside reporting is one way to improve communication among the health care team. At the study site, at least 50% of bedside reporting was being conducted at the door of the patient's room instead of at the patient's bedside. The project question addressed whether a computer-based education and training video on bedside reporting and a standardized bedside reporting checklist would increase the rate of bedside shift-to-shift reporting among a medical surgical unit (MSU) to 100%. The project addressed the implementation of standardizing bedside reporting through education and training using Agency for Health Care Research and Quality's (AHRQ) Guide to patient and family engagement. The project also promoted use of a standardized tool to conduct bedside reporting and a surveillance tool to ensure bedside reporting was being conducted. Data was collected through surveys and surveillance. The data was tabulated for frequencies displayed in percentages. Post-implementation findings indicated that bedside reporting went from 0% to 86% during the 2-week surveillance period. MSU nursing staff improved their knowledge and skill on how to conduct bedside reporting, but their attitude did not change as they thought the practice of bedside reporting was not an effective use of their time. Findings may be used to increase involvement of patients and families in their inpatient health care.

Bedside Reporting: Improving Practice

by

Lori C. Wichman

MSN, Walden University, 2013

BSN, California State University, Sacramento, 2003

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

December 2017

Table of Contents

List of Tables

List of Figures

Section 1: Bedside Reporting: Improving Practice

Communication errors have been shown to be among the top three causes for sentinel events (Agency for Health Care Research and Quality, n.d.). The Joint Commission in 2009 added managing hand-off communication to the National Patient Safety Goals (Trossman, 2009). Patients have identified that they are unsure about what occurs during their hospital stay (Timonen & Sihvonen, 2000). Patients also reported that they feel that health care workers are trying to keep information from them or speak poorly about them (Timonen & Sihvonen, 2000). This lack of information also prevents patients from being able to speak to the activity that occurred during their hospitalization at their follow-up appointment with their provider (Timonen & Sihvonen, 2000).

The 2001 Institute of Medicine report, *Crossing the Quality Chasm*, indicated that shift-to-shift reporting should be standardized in an effort to prevent errors (Trossman, 2009). With the implementation of TeamSTEPPS® at the Medical Group (MDG) at a large Department of Defense (DoD) hospital, a decrease in errors was found over a 4-year period (Enfinger, Garder, & Durant, 2013). However, shift-to-shift bedside reporting was not implemented at the 673rd MDG during this 4-year period. This project was conducted to improve the practice of bedside reporting. Section 1 includes the background, context, and reason for the selection of improving the practice of bedside reporting as the project topic.

Background/Context

The medical surgical unit's (MSU) mission is to provide around-the-clock inpatient medical services to 166,000 member population composed of active duty

service members and their families, retired Department of Defense (DoD) and Veteran Affairs (VA) beneficiaries (JBER, 2014). The Medical Group is the largest hospital in the Pacific Air Force (JBER, 2014). Clinical operations on the unit include 25 beds, 24 active duty nurses, three VA nurses, 14 technicians, and 79 medical providers in 17 service lines of care for 1,200 annual patients (JBER, 2014).

The MDG in 2009 had started using the Talk to Me: Reducing Issues Related to Communication initiative to reduce errors related to communication (DoD Patient Safety Program, 2015). In 2011, the MDG implemented TeamSTEPPS®, a program to improve interprofessional communication developed by the Agency for Healthcare Research and Quality (AHRQ) (Enfinger, et al., 2013). The MDG saw a reduction in errors over a 4-year period (Enfinger, et al., 2013). In 2012, the DoD instructed all military health organizations to implement bedside reporting as a way to engage patients in their care (American Institutes for Research, 2012). With the success of TeamSTEPPS®, the MDG was ready to implement bedside reporting. However, according to the pre-implementation survey conducted on the unit, 12 of 24 nurses reported that they were uncomfortable speaking in front of the patient, they believed that the Health Insurance Portability and Accountability Act (HIPPA) may be violated, and they did not want to awaken or disturb the patient to give a report. These concerns have led to resistance in conducting bedside reporting.

I selected the topic of bedside shift-to-shift reporting to improve satisfaction and accountability among the nursing staff with bedside reporting and overall improve patient outcomes (Jeffs et al., 2013). The practice on the MSU was nurses went into the report

room to get a broad report from the off-going charge nurse on the floor. Oncoming nurses would meet with the off-going nurses to conduct the shift report. The nurses walked to the patient's room, stood at the door, and conducted the report. Then they went to the next door and conducted the report on the next patient. Occasionally, nurses would go into the room and conduct the report at the bedside, but the patient had very little involvement. Then the nurses would complete the report at the nurses' station to discuss other relevant information. When finished, the off-going nurses would leave and the oncoming nurses would go to their computers to check the medication administration records, orders, and e-mails. From observation of the practice of shift-to-shift bedside reporting on the MSU, was one or fewer shift-to-shift were conducted at the bedside per shift.

Improved bedside shift-to-shift reporting was needed to enable the MSU to meet the organization's mission, vision, and goal. The mission of the organization is the following:

> Enable global power projection. Deliver quality services. Be the hospital of choice. The vision is to making lives better, serving warriors, families and veterans. Finally, the goal was to enable mission partners. Sustain America's arctic power projection platform. Provide mission-ready warriors. Serve our families and joint base community. (JBER, 2014)

Bedside reporting expedites the transfer of the patient's trust from one nurse to the next (Baker, 2010).

Problem Statement

The nurses at the MSU had been instructed to conduct bedside reporting. During unit observations, it was identified that bedside shift-to-shift reporting was occurring outside the patient's room. The MSU nursing staff at the MDG are resistant to bedside nurse-to-nurse reporting. Bedside reporting was implemented without education on how to conduct bedside reporting, and bedside nurse-to-nurse reporting was not standardized because there was no standardized tool to assist with bedside reporting. A discussion with the nurses indicated that 50% conducted bedside reporting in the hallway near the door to the patient's room. Twelve percent of the nurses indicated that they did reporting at the bedside with the patient; however, all nurses indicated that reporting was incomplete due to their concern about violating the HIPPA privacy rules. The intent of the project was to have 100% of the nursing staff adopt the practice of bedside shift reporting through education, training, and standardization.

Purpose Statement

The purpose of the project was to improve the practice of bedside reporting, with each nurse conducting bedside reporting 100% of the time. Education and training for bedside shift-to-shift reporting and a standardized bedside reporting checklist tool were used to increase compliance to 100%. The AHRQ (2014) identified that implementation of bedside reporting has been limited due to lack of education on how to perform beside reporting and the absence of standardized tools. Previously, one nurse per shift conducted bedside reporting at the MSU. The project included giving nurses the knowledge and

skills to conduct bedside reporting. The knowledge and skills should empower nurses to engage the patient and each other at the bedside for improved practice.

Project Objectives

The practice initiative had three objectives. The first was to modify the AHRQ PowerPoint presentation to meet the specific needs of the MSU. The PowerPoint presentation included the purpose of and method to conduct bedside reporting to educate MSU staff (AHRQ, 2014). Education and training has been shown to improve bedside reporting compliance (Jeffs et al., 2013). It was necessary to obtain support from the key stakeholders, in this case the MSU nursing staff (see Brenowitz & Manning, 2003).

The second objective was that 100% of the MSU nursing staff would use a standardized tool, the AHRQ Bedside Shift Report Checklist, to perform the bedside shift-to-shift report (Appendix A). Having a standardized tool that all nursing staff used would help ensure uniformity in the shift-to-shift bedside report from each nurse (see Jeffs et al., 2013).

The third objective was to determine whether training would enable the MSU nursing staff to conduct bedside shift-to-shift reporting at a rate of 100%, as measured by the MSU Bedside Reporting Surveillance Checklist (Appendix B). With support of the chief nurse (CN), clinical nurse specialist (CNS), and flight commander, the barrier of lack of leadership for bedside shift reporting would be eliminated. Leadership's endorsement of bedside shift reporting demonstrated to the nursing staff their commitment to the practice. The other barrier that was eliminated was the barrier of the

lack of training and education related to bedside report (see Wakefield, Ragan, Brandt, & Tregnago, 2012).

Project Question

The project question was as follows: Would computer-based training on the importance of and method to conduct bedside reporting as well the use of a standardized bedside reporting checklist increase the rate of bedside shift-to-shift reporting among nurses in the MSU to 100%?

Significance of Project

The literature indicated that bedside reporting met the National Patient Safety Goals by improving the accuracy of patient identification as both nurses identified the patient by using two patient identifiers (Baker, 2010). Improving communication among caregivers ensures that bedside reporting gives all team members an opportunity to ask and respond to questions posed by the team members, and "encourages patients to be actively involved in their care" (Baker, 2010, p. 355). Nurses at the Alaska Native Medical Center identified that bedside reporting had decreased report time by 15 minutes, enabling the nurses to leave work 15 minutes earlier (Porter, 2015). Nurses also identified that they were more satisfied with bedside reporting as the nurse from the off-going shift was more accountable and that the nurses were able to prioritize their patients' care needs (Baker, 2010).

Bedside reporting also helped to prevent communication errors. The health care team, which includes the patient, can correct errors or misunderstandings during bedside shift reporting (Baker, 2010). The Joint Commission (2012) identified that

communication errors have consistently been among one of the top three reasons for a sentinel event, as shown in Figure 1.

Events Reviewed by The Joint Commission by Year

The majority of events have multiple root causes
(Please refer to subcategories listed on slides 5-7)

2012 (N=901)		2013 (N=887)		Jan to Jun 2014 (N=394)	
Human Factors	614	Human Factors	635	Human Factors	290
Leadership	557	Communication	563	Leadership	269
Communication	532	Leadership	547	Communication	248
Assessment	482	Assessment	505	Assessment	208
Information Management	203	Information Management	155	Physical Environment	53
Physical Environment	150	Physical Environment	138	Care Planning	38
Continuum of Care	95	Care Planning	103	Information Management	36
Operative Care	93	Continuum of Care	97	Continuum of Care	33
Medication Use	91	Medication Use	77	Operative Care	29
Care Planning	81	Operative Care	76	Health information technology-related	27

Figure 1. Events reviewed by The Joint Commission by year (The Joint Commission, 2014).

Reduction of Gaps

Previously, there was no education given to the nurses related to bedside shift reporting. The project was conducted to reduce the gap in practice with the use of the standardized education and training. Traditional reporting resulted in communication errors, including the patient not knowing the plan of care and medical errors. A more effective bedside shift report method was needed to enhance communication and decrease adverse events. Evidence-based practice (EBP) supported the change to bedside reporting, as it demonstrated that effective bedside shift-to-shift reporting would result in more patient satisfaction because patients felt included in their care (McMurray, Chaboyer, Wallis, Johnson, & Gehrke, 2011). Bedside shift reporting would also allow

the nurses and patients to identify and fix inaccuracies (Evans, 2013; McMurray et al., 2011).

Implications for Social Change in Practice

The implications for social change include a more knowledgeable patient population as patients take a more active role in their care, which may result in better patient outcomes. Communication between the patient and nurse had been mostly nurse or physician driven, as opposed to a team or partnership with patients in the discussion of their care (AHRQ, 2010). With team communication and patient- and family-centered care, there is a power shift from the health care worker to the patient (Institute for Patient- and Family-Centered Care, 2010). The power shift allowed patients to make informed decisions about the care they received. Bedside shift reporting also increases health care literacy among patients who are able to provide more accurate information regarding their hospitalized care to the primary care provider. In turn, patients may become more compliant with their health care regimens as culturally congruent care is being provided (Kelly & Tazbir, 2014). Patients engaged in their health care are more likely to be compliant with their discharge instructions.

With the focus in health care transitioning from illness to preventative health and health promotion and to patient- and family-centered care, the care the patient is receiving is congruent with the patient's culture, heritage, and lifestyle. The congruent care ensures that patient is more compliant with the plan of care, including diet and activity, as the care is designed for each specific patient (Gonzalo, 2011). Communication with the patient at the bedside opens communication channels from one-way to two-way

communication. This is a small step that may lead to a more knowledgeable, healthier, and more satisfied patient population, and may decrease hospital admissions.

Definitions of Terms

Bedside reporting: The process where nurses conduct change of shift report at the bedside so the patient can be included (Anderson & Mangino, 2006). For this project the definition of this process included the following steps: First, the on-coming nurse is introduced to patients and family members (if the patients want the family members present). The nurses then review the situation, background, assessment, and recommendations (SBAR). Next, the nurses will conduct a patient safety check (ID band, incision, IV site, PCA settings, drains/foley, and fall risk), check the environment for safety (call bell, walker in reach, bed alarm), update the white board with name/phone number, and ask the patient (and family) if they have anything to add or have questions" (Malkowiak & McConnell, 2014).

Congruent care: Cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are tailored to fit the individual, group, or institutional values, beliefs, and lifestyles to provide or support meaningful, beneficial, and satisfying health care or well-being services (Gonzalo, 2011).

Patient- and family-centered care: "Patient- and family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. It redefines the relationships in health care. Patient- and family-centered practitioners recognize the vital role that families play in ensuring the health and well-being of infants,

children, adolescents, and family members of all ages. They acknowledge that emotional, social, and developmental support are integral components of health care. They promote the health and well-being of individuals and families and restore dignity and control to them" (Institute for Patient- and Family-Centered Care, 2010).

Assumptions, Limitations, and Delimitations

Failure occurs from lack of training (Wakefield et al., 2012). Success comes from support of nursing and executive leadership (Longenecker, 2014). One assumption was that nurses would want and would use the training and education to improve their bedside reporting practices. Another assumption was that the newer nurses had training in bedside reporting during their residence in the Air Force's nurse transition program. A final assumption was that nursing leadership would support the practice of bedside reporting after the change in assignments between 2016 and 2017.

One limitation to effective implementation was the turnover rate as nurses move from one unit to another or move to another duty station. This posed a risk to sustainability of the project. As unit and nursing leadership changes, there is a risk of the unit reverting to its previous shift reporting practice. A second limitation was that there were three Veterans Affairs (VA) nurses whose leaders were not located on the unit or within the MDG. Instead, the VA chief nurse was in another building; therefore, ensuring participation in bedside shift reporting required the MDG chief nurse to speak with the VA chief nurse to ensure the VA nurses complied with the change in practice. A third limitation was that the project leader was not active duty Air Force, but a retired Air Force Major, and no longer had the authority that came with rank, which made leadership support more important.

The delimitation was that the project was restricted to the MDG MSU and the nursing staff. The participants were 24 active duty nurses and three VA nurses. The project objectives also ensured that the project was limited to the specific unit and participants, and did not extend beyond the boundaries of the project.

Summary

The MDG is the largest Air Force hospital in the Pacific Command, and is seen as a leader in the Alaska health care community (JBER, 2014). The MDG had led the way with the implementation of TeamSTEPPS® but has struggled with the implementation of change-of-shift bedside reporting on the MSU due to lack of education and training of nurses. The project of improving the practice of bedside reporting would give the nursing staff the tools and skills needed to successfully engage in bedside reporting, which would increase the compliance of the practice and help the nursing staff to be more engaged with their communication (AHRQ, 2014; Baker, 2010). A more knowledgeable team, which includes the patient and family, allows patients to make the best decisions regarding their care (AHRQ, 2014).

Section 2: Review of Scholarly Evidence

Scholarly evidence supported process improvement and implementation of the improved practice, in this case bedside shift-to-shift reporting. Scholarly evidence was needed to support the change in practice, which included a computer-based training program on bedside reporting and a standardized bedside reporting checklist to increase the rate of bedside shift-to-shift reporting among nurses in the MSU to 100%. Also, scholarly evidence included EBP that was successful in other organizations and settings. Scholarly evidence indicated barriers and facilitators that researchers identified. Section 2 includes a review of the specific and general literature on the topic of bedside shift-to-shift reporting, and the framework for the project.

Search Strategy

I conducted a literature review using the Cumulative Index to Nursing and Allied Health Literature (CINAHL), EBSCO, Cochrane Database of Systematic Review, and Google Scholar. Boolean operators were used in the searches to allow for the grouping of ideas, phrases, and terms (see Burns & Grove, 2009). The Boolean search string for the clinic problem was *bedside reporting* AND *communication* OR *patient communication* AND *patient centered care* OR *family centered care* OR *interprofessional communication* OR *team communication* OR *collaboration* OR *patient involvement* OR *team conflict* OR *rounding*. Articles had to be full text, published in peer-reviewed journals, and published between 2000and 2014. Several articles were rejected, including those published prior to 2000, editorials, non-peer-reviewed publications, and a poster presentation. A total of 38 articles were used (see Appendices C and D).

Specific Literature Review

A literature review was conducted to identify current practices in bedside reporting. The literature review allowed me to identify challenges that had been addressed in previous projects. The literature review sections include bedside reporting, barriers to bedside reporting, patient communication, and transforming care at the bedside.

Bedside Reporting

Bedside reporting is a way to ensure that patients are informed and included in their care and the planning of their care (Maxson, Derby, Wrobleski, & Foss, 2012). Instead of nurses obtaining shift reports at the nurses' station or in a report room, the off-going and oncoming nurses conduct shift reports in front of the patient at the bedside (Maxson et al., 2012). Nurses identified that they are able to prioritize and plan patient care for the day (Maxson et al., 2012). Both nurses and patients had a positive feeling toward the practice (Maxson et al., 2012). Patients suggested that they liked the practice of bedside reporting and they felt bedside reporting decreased confusion (Maxson et al., 2012). Nurses commented that it decreased the number of times the patient used the call light and led to better use of the nurse's time (Maxson et al., 2012). Findings from the Maxson et al. (2012) study supported the project of improving the practice of bedside reporting on the MSU. The educational compent of the the project included the positive impact of bedside reporting as identified by Maxson et al. (2012), which was a decrease in confusion about the plan of care. The MSU nurses complained about how often call

lights were used, and Maxson et al. observed that bedside reporting decreased the use of call lights.

Bedside reporting is the transfer of care from one shift to another (Novak & Fairchild, 2012). Novak and Fairchild (2012) noted that bedside reporting has a fiscal impact on an organization as bedside reporting decreases report times, which increases nurse satisfaction, nurse retention, and patient and family satisfaction, and decreases errors associated with health care . In addition, bedside reporting decreases patient anxiety as patients are more aware of the care that they have or will receive during their course of stay (Novak & Fairchild, 2012). Standardized bedside reporting decreases confusion about care expectations, and builds patient trust with the hosptial and health care workers (Novak & Fairchild, 2012). Findings from Novak and Fairchild (2012) study supported the project by providing additional support for improving the practice of bedside reporting. Retention on the MSU was an issue, as after 2 years most active duty MSU nurses wanted to transition to another area of nursing because the MSU was viewed an area for new nurses. In 2011, the MDG introduced TeamSTEPPS to improve communication and decrease errors associated with health care. TeamSTEPPS did decrease errors; however, there still is room for improvement (Enfinger et al., 2013). Novak and Fairchild's findings were included in the nursing staff education component to explain how bedside reporting can be beneficial to the nursing staff, improve the quality of care provided, and decrease errors.

Stickney, Ziniel, Brett, and Truog (2014) conducted a study on bedside reporting that involved 21 parents and 24 health care providers in a pediatric unit. The parents

enjoyed being a part of the bedside reporting as they were the experts in how their child normally acts outside of the health care setting (Stickney et al., 2014). The health care team felt that they were able to ensure that the parents' expectations were reasonable, and the bedside reporting ensured everyone was on the same page (Stickney et al., 2014). However, the health care team members identified that they could not have candid converstations and provide education among themselves (Stickney et al., 2014). The MSU is the multiservice unit that includes pediatric patients. Stickney et al.'s (2014) findings validated concerns that the MSU staff had about about bedside reporting. Stickney et al.'s findings were used in the educational component of the project about the importance of bedside reporting and the impact it has on the patients despite the nurses' concerns about their ability to be candid with each other.

Bedside reporting was not occuring on the MDG MSU, as the nurses commented that they did not want to disturb the patients. Bedside reporting was mostly conducted outside the patient's room. Bedside reporting would allow the nurses on the unit to identify patient care issues that must be addressed immediately, such as intravenous lines running properly, or to determine whether the patient's condition deteriated since the last check. The literature review findings on the topic of bedside reporting were included when providing education to the MSU nursing staff to promote proper practice.

Barriers to Bedside Reporting

In 2011, St. Vincent Infirmary Medical Center (SVIMC) implemented bedside reporting. Frazier and Garrison (2014) identified that SVIMCs transition to bedside reporting on three surgical units and one medical unit over 3 months was not sustainable.

Frazier and Garrison observed contributing factors to effective reporting were related to the barriers to bedside reporting. Frazier and Garrison used a postimplementation survey that consisted of six questions addressing potential barriers identified in the previous attempt to implement bedside reporting. Frazier and Garrison found that the areas that needed to be addressed were staff education, communication, accountability, and competency in all hospitals that were implementing bedside reporting. Barriers are presented in Table 1.

Table 1

Barriers to Bedside Reporting

• No clear communication for why the practice change was necessary
• No education about how to perform the practice
• Lack of communication to staff about how the practice change was improving patient care
• No staff accountability to implement the practice
• Lack of practice validation post-implementation

Frazier and Garrison (2014) noticed that there was a need for a change in the process of shift change because patients were not participating in their care, the nurses were spending an excessive amount of time during shift report, and there was a lack communication among the nursing staff. Leadership support and collaboration in the design of the practice helped to communicate the need for the change (Frazier & Garrison, 2014). Frazier and Garrison noted that sustainability of any change can be difficult unless the potential barriers are addressed. Frazier and Garrison's (2014) findings were important to the project because they validated concerns related to bedside reporting sustainability. Frazier and Garrison also examined why change on an inpatient unit may not be sustainable. In the project, I addressed each barrier in the educational

component, which included a video on how to conduct bedside reporting. In addition, I implemented a feedback mechanism related to the effectiveness of the practice for the nursing staff. Nursing staff will be held accountable by MSU leadership, who will use the data from the practice survey to identify whether staff are properly conducting bedside reporting (see Appendix B).

Wakefield et al. (2012) examined whether implementation and sustainment of bedside reporting was successful. The study included 32 full-time nurses and 20 staffed beds, with a patient-to-nurse ratio of 3 to 1. Wakefield et al. emphasized that communication must be conveyed to the nursing staff as to why the practice change is necessary. Wakefield et al. gained approval for the practice change from Unit Nursing Shared Governance Council to trial bedside reporting. For the current DNP project, approval was obtained from the chief nurse executive, the flight commander, the clinical nurses specialist, and the unit practice committee. The PowerPoint presentation, which was part of the education component presented to the MSU nursing staff, included information of the benefit of bedside reporting as compared to the current practice.

Frazier and Garrison (2014), noted that during the initial attempt to implement bedside reporting no one updated the staff as to how the new practice had improved patient care. Wakefield, et al. (2012) provided monthly updates to the nursing staff regarding patient satisfaction. Nurses are critical thinkers, and as such, need feedback to evaluate the effectiveness of an intervention. Frazier and Garrison (2014), and Wakefield, et al. (2012), both identified the lack of feedback as problematic, however, Frazier and Garrison provided the feedback three months post-implementation. The current DNP

practice project will include feedback from the unit flight commander with monthly patient satisfaction scores that will be presented to the nursing staff during the monthly staff meeting. The satisfaction scores will be delayed by two months, as the data is gathered by a third-party that conducts the patient satisfaction survey.

After implementation of the practice change sustainability becomes a factor in successful implementation (Frazier & Garrison, 2014). Accountability for conducting bedside reporting lies with the individual nurses. Leadership involvement on a daily basis ensures that nursing staff are conducting bedside reporting as provided in the education of the practice. There was daily leadership support either by the nurse manager and "mystery audits" in the Frazier and Garrison (2014) study or by the unit educator and supervisors in the Wakefield, et al. (2012) study. Accountability of the nursing staff for this planned project will come from the shift charge nurse, unit CNS, and unit flight commander.

Finally, both Frazier and Garrison (2014), and Wakefield et al (2012) concluded that practice validation was necessary. Frazier and Garrison (2014) noted as much as a 60-point increase in patient satisfaction in a one-year period post implementation of bedside reporting. For sustainability, and to ensure the nursing staff had not slipped back to their "old ways", the nurse manager conducted post-implementation surveys of practice that identified the occasional need for reeducation (Frazier & Garrison, 2014). Wakefield, et al. (2012) noted a 6.9-point increase in satisfaction with the bedside reporting process after a 23-month post-implementation period. Wakefield, et al. (2012) identified the need for occasional monitoring and re-education as needed to ensure

sustainment. For the project, sustainability had been a concern as nurses move across the hospital and throughout the Air Force every two to four years. For this reason, the MSU Bedside Reporting Surveillance Checklist has been developed to be conducted by the unit patient safety officer (Appendix B). The data collected may be used to help the CNS, flight commander, and chief nurse evaluate the need for reeducation on the unit.

Patient Communication

Patients have the right to be informed of their care so they can give proper consent for that care (McMurray, Chaboyer, Wallis, Johnson, & Gehrke, 2011). The current literature has identified that patients are more satisfied with bedside reporting because they feel included in their care, and it gives them an opportunity to fix inaccuracies (McMurray, et al,. 2011). McMurrary, et al (2011), study's focus was on the patient's perception of bedside reporting. At first, the ten patients felt that their communication was to be passive instead of active, but as patients were made aware of the practice of bedside reporting they become more active in their care (McMurray, et al., 2011). Patients appreciated the interactive nature of communicating with the nurse at the bedside (McMurray, et al., 2011). The article supports the practice of bedside reporting as it shows that the more informed and active patients are in their care, the more the patient is satisfied with their care. McMurray et al (2011), also identified that inaccuracies can be fixed during bedside reporting that can prevent major medical errors, therefore providing credence to the practice for the MSU nurses.

Timonen and Sihvonen (2000) compared 118 nurses' and 74 patients' opinions of the purpose of bedside reporting, patient participation and promoters and barriers to

patient participation in bedside reporting. The same questionnaire surveys were given to both the nurses and the patients, in addition to 76 bedside reports being observed (Timonen & Sihvonen, 2000). Nurses also performed peer to peer observations of bedside reporting sessions and were trained to complete the observation form (Timonen & Sihvonen, 2000). The results indicated that all the nurses felt that the bedside reporting was useful for both the nurse and the patient, however, 27% of the patients felt that bedside reporting was a source of information only for the nurses (Timonen & Sihvonen, 2000). The nurses also felt that the patients were interactive in the reporting, however, 48% of the patients felt that the nurses talked to each other or one nurse did most of the talking (Timonen & Sihvonen, 2000). Promoters used in bedside reporting included encouraging patients to ask questions, fostering participation by relatives, and having no discussion of very personal matters (Timonen & Sihvonen, 2000). Barriers included nurses concentrating too much on patient documents, presence of other patients in the room, too many staff members taking part in reporting, nurses too far from the bed, nurses using medical jargon, and too little time for each patient (Timonen & Sihvonen, 2000). These concerns will be included in the bedside reporting patient information pamphlet on the practice of bedside reporting. The pamphlet will be customized to the organization, and given to the patients on admission. The admitting nurse will explain to the patient and family that bedside reporting is conducted at change of shift on the unit and will emphasize to the patient and family that their participation in bedside reporting is welcomed. During shift change, the off-going nurse will introduce to the patient the on-coming nurses and then welcome the patient to participate in the bedside report.

Transforming Care at the Bedside

Transforming care at the bedside includes the involvement between frontline nurses, patients, and families (Dearmore, et al., 2013). Deamore, et al. (2013), examined bedside reporting initiatives to determine if they are effective in transforming care at the bedside. Nurses identified that bedside reporting has challenged them to be more innovative in their communication skills (Dearmore, et al., 2013). Part of communicating with patients and families was the use of the white board to keep the patient and family up to date on when they could receive their next pain medication, as well as to write down daily goals as a visual reminder (Dearmore, et al., 2013). It was also found that pain was under more control when nurses are performing hourly rounding and bedside communication (Dearmore, et al., 2013). When engaging patients at the bedside the nurses discovered that their time with direct patient care increased and nursing overtime decreased, which was an added value for the patient, nurse and the organization (Dearmore, et al., 2013). The study provides supports that will help to get buy-in from nursing staff who currently see bedside reporting as a waste of their time.

Transforming care at the bedside includes engaging patients and families in the patient's plan of care. Bedside reporting will help the patient see that they are a valued member of the healthcare team. The nursing staff on the MSU will be provided education in the form of a PowerPoint presentation that explains that communicating with their patients during bedside shift report, in addition to communicating with the patient throughout the shift, can decrease the use of nurse call lights and decrease the patient's pain, and improve patient overall satisfaction of care. The MSU nurses have already been

transforming care at the bedside by providing EBP that not every patient needs vital signs obtained every four hours. The nursing staff will be shown that bedside reporting is another way to transform care at the bedside.

General Literature Review

A general literature review was conducted which was related to ways to improve communication through team training. One issue that MSU nursing staff have identified was feeling uncomfortable about speaking about the patient in front of the patient. This was to identify different learning experiences that could be used for bedside reporting training and education. In the general literature review the topics that will be addressed are SBAR, team training, team communication, and nurse-provider communication.

Situation, Background, Assessment, and Recommendation

Situation, background, assessment, and recommendation (SBAR), is a communication method that can be used between a nurse and a provider (Boaro, Fancott, Baker, Velji, & Andreoli, 2010). The SBAR method of communication provides gives only pertinent information and omits information that does not hold value for the situation (Boaro, et al., 2010). The value in using SBAR is that the communication process depersonalizes issue teams may have with one another or with the patient (Boaro, et al., 2010). The SBAR process can also be used in urgent and non-urgent situations, and has decreased the time of superfluous communication (Boaro, et al., 2010).

The framework of SBAR provides standardization communication from nurse to nurse and unit to unit during hand-over of patient care (Novak & Fairchild, 2012). Novak and Fairchild (2012), concluded that SBAR is a standardized tool that meets the National

Patient Safety Goal requirements. It was also found that SBAR reduced the risk for fragmented care and communication errors as information provided is clear and concise (Novak & Fairchild, 2012). For SBAR to be effective, nursing staff must have training to sucessfully use the technique among nurses, providers, and patients and their families (Novak & Fairchild, 2012).

The nursing staff on the MSU have all completed TeamSTEPPS training which included how to use SBAR. The project includes using SBAR as a key tool in communicating information during bedside reporting. Novak and Fairchild (2012), provided evidence that SBAR reduces communication errors and validated the TeamSTEPPS training the MSU nurses have completed.

Team Training

Patient care requires team work and has the potential for life altering and fatal outcomes if there is poor team communication and coordination (Weaver, Rosen, Salas, Baum, & King, 2010). Weaver, et al. (2010) conducted a meta-analysis of 93 studies involving 2,650 teams. Salas, et al. (2008), also conducted a meta-analysis of 41 studies which involved a total 2,502 teams. Both meta-analyses concluded that training as a team resulted in improved communication, decreased errors, and decreased time in completing a procedure (Weaver, et al., 2010; Salas, et al.,2008). Team training provides the team with the knowledge, skills, and attitudes to work effectively (Salas, et al., 2008). The most important component of team training is communication (Salas, et al., 2008; Weaver, et al., 2010).

TeamSTEPPS provided tools and techniques for healthcare teams to improve team communication and improve teamwork aimed at improving healthcare outcomes (Agency for Healthcare Research and Quality, 2010). TeamSTEPPS training was completed annually, and with Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advance Life Support (PALS), and evaluated during mock code blue exercises on the unit. TeamSTEPPS training has also provided education and training on different communication techniques that nursing staff can use to solve conflict (AHRQ, 2010). The powerpoint presentation that will be used for the educational component of the project to improve the practice of bedside reporting incorporates AHRQ bedside report training. The powerpoint presentation will also reiterate that the patient is a team member. The nursing staff need to understand the importance of the patient as a team member, and as such, the patient needs to be included in the communication as with any other member of the healthcare team.

Team Communication

Feeling misunderstood can cause conflict and lead to errors (Condon, 2008). Barbara Backer Condon (2008), discussed how the concept of feeling misunderstood can have consequences. Feeling was defined as, "a state of mind, easily moved emotionally; expressing emotion or sensitivity" and misunderstood as, "improperly understood; taken in a wrong sense" (Condon, 2008, p. 179). "The characteristics of feeing misunderstood are disquietude, discordant perceptions, and heightened awareness of emotions (Condon, 2008, p. 181)." The characteristics are relevant to nursing and clinical practice as emotions and perception can create a fog that may distort the communication. The fog

that may distort communication may increase errors in patient care caused by ineffective communication, and possibly result in mismanagement of a disease process (Condon, 2008). Feeling of misunderstood may affect the interdisciplinary relationships that allow for effective collaboration for better patient outcomes (Forces of Magnetism, 2011).

Nurse-Provider Communication

Nurses and providers do not take classes on how to communicate with each other. Brigitte S. Cypress (2011), clarified the attributes and antecedents of nurse-provider communication and the consequences of the communication between the two professions. Although multiple definitions of communication were presented, the main definition provided is "Communication is an act or instance of transmitting, a process by which information is exchanged between individuals through a common system of symbols, and the activity of conveying information" (Cypress, 2011, p. 32). The definition of communication is similar in healthcare, such as with written orders, approved abbreviations and symbols.

The characteristics that define the concept of nurse-physician communication are, "accuracy, understandability, timeliness and availability, reliability, consistency, balance, repetition, cultural competence, and openness" (Cypress, 2011, p. 33). These characteristics are relevant to nursing and clinical practice, as communication must be accurate to ensure that the proper care is given to the patient, that the communication is understandable to all who are sending and receiving the communication, and that the communication is received in a timely manner and not after it is no longer relevant.

Cultural competence is important for both, the nurse and the patient as culture plays a role in understandability.

Summary

The literature review found that the literature is primarily qualitative and with small populations or included one healthcare facility and multiple units. The literature review, both specific and general, provide that current literature exists and supports the practice of bedside reporting. Patient safety improves when the patient is involved in the plan of their care (McMurray, et al., 2011). Communication with the patient and the rest of the healthcare team is paramount to improved patient health outcomes (Maxson, et al., 2012). Bedside reporting can improve communication between the patient and the nursing staff (Tan, 2015). Improving the practice of bedside reporting requires that barriers are overcome through education and training (Frazier & Garrison, 2014). The literature review provided evidence-based practice to provide for an opportunity to learn from the mistakes and sucesses of others who have implemented the practice.

Section 3: Approach

Quality improvement (QI) is a continuous process to ensure that the improvement has been effective. Improving the practice of bedside reporting required the ability to measure whether an improvement had been made. Three QI tools were used to collect the data to determine whether an improvement had occurred. The QI project was conducted to evaluate the effectiveness of the project using a one-group pretest-posttest design. Section 3 includes the project design, population and sampling, data collection and instruments, protection of human subjects, data analysis, and project evaluation plan.

Project Design

The purpose of the project was to improve the practice of bedside reporting, with each nurse conducting bedside reporting 100% of the time. The project included a one-group pretest-posttest design. After obtaining institutional review board (IRB) approval, number 06-21-17-0281863 and prior to implementing the training, I gave a preeducation and training survey to the nursing staff addressing their thoughts, feelings, and attitudes toward the current practice of bedside reporting used on the MSU (see Appendix E). The practice initiative had three objectives. The first objective was to modify a PowerPoint presentation that detailed the purpose of and method to conduct bedside reporting to educate MSU staff. Education and training had been shown to improve bedside reporting compliance (Jeffs et al., 2013). As with any planned change, obtaining buy-in from the key stakeholders helps to ensure the training is completed, (Brenowitz & Manning, 2003). The PowerPoint was presented to the nursing

staff, and the new practice was implemented at the direction of the flight commander with the support of the chief nurse executive and the clinical nurse specialist.

The second objective was that 100% of the MSU nursing staff would use a standardized tool, the AHRQ Bedside Shift Report Checklist, to perform the bedside shift-to-shift report (Appendix A). Having a standardized tool that all nursing staff used would ensure there was uniformity in the shift-to-shift bedside report from each nurse (see Jeffs et al., 2013). The AHRQ Bedside Shift Report Checklist reinforced the education and training presented in the PowerPoint.

The third objective was to determine whether education and training would enable the MSU nursing staff to conduct bedside shift-to-shift reports at a rate of 100% as evaluated by the MSU Bedside Reporting Surveillance Checklist (Appendix B). Once the education and training for the practice of bedside reporting was implemented, the posteducation and training survey (Appendix C) was administered 2 weeks later in the same manner as the preeducation and training survey. After completion of the posteducation and training survey, the data from the pre- and posteducation and training survey and surveillence checklist were presented to the nursing leadership and MSU nursing staff.

Population and Sampling

Setting

The project was conducted at the MDG located on a military hospital in Alaska. The MDG has approximately 1,300 employees and cares for 36,754 enrolled beneficiaries; however, there was a total of 166,000 beneficiaries who could receive care

at the organization (Bisnett, 2014). The population categories included active duty, active duty family members, retirees, and other.

> The MDG is 1.2 million square feet and valued at $191 million of which the Department of Veterans Affairs contributed $11 million. As a true Joint Venture, the Medical Group and Department of Veterans Affairs have one standard of care, integrated staff and integrating processes. There are total of 79 staffed beds that comprised of 53 inpatient beds, 22 same-day surgery beds and 4 antepartum beds. (JBER, 2012)

The organization provides primary and specialty care and inpatient units (Bisnett, 2014). The MSU was the unit where the process improvement was implemented. The MSU is a 27-bed unit that cares for pediatric to geriatric patients with a wide range of illnesses, injuries, and post-surgical procedures.

Population

I used convenience sampling to recruit 24 active duty and three VA nurses who worked on the MSU at the MDG in Alaska. The active duty nurse experience ranged from less than 1 year to approximately 10 years. The MSU leadership had 10 years or more of experience. The nursing staff self-schedules and rotates every 3 months between day and night shift. The VA nurses had a minimum of 2 years of experience. All nurses were BSNs, and some of the active duty nurses were working toward the MSN.

Data Collection

The goal of the project was to improve the practice of bedside reporting by increasing the nursing staff's knowledge and skills and changing their attitude toward

bedside reporting to ensure sustainment. “Data is the foundation in healthcare improvement” (D’avolio, 2015), and it was important to have a reliable approach to collect data. After obtaining approval from the Walden IRB and the MDG chief nurse, I began data collection. The nurses were required to participate as directed by the chief nurse. I left an invitation letter to participate in the MSU break room (see Appendix F). In the letter the nurses were asked to complete the pre-education survey and the training video that had been embedded in the PowerPoint presentation. The paper-and-pencil pre-education and training survey addressed the nursing staffs’ perception of their level of satisfaction with bedside reporting practice (Appendix E) (see Frazier & Garrison, 2014). The paper-and-pencil survey and a collection box were left for 1 week in the staff break room to be completed at the nurses’ leisure. The collection box was sealed with a label that was stamped over the box to indicate whether the seal had been broken. There were no identification numbers given on the surveys to match the pre- and post-education and training surveys because I was looking at the overall increase in satisfaction of the nurses and not the individual increase in satisfaction of bedside reporting. To protect the privacy of participants, I did not enter the break room during the observation and surveillance periods. E-mail or online surveys were not used at the recommendation of the MSU nursing leadership because nurses may not have been receptive to them.

At the recommendation of MSU leadership, the education and training PowerPoint presentation was sent to the nursing staff 1 week after the collection of the pre-education and training surveys. The education and training included the Guide to Engaging Patients and Families at The Bedside PowerPoint presentation developed by

AHRQ (2014), with a 3-minute and 10-second training video of the components of bedside reporting and how it should be implemented (Appendix G). The PowerPoint presentation and video took a total of 10 minutes to view. The MSU flight commander e-mailed the PowerPoint presentation to the nursing staff to view on the computer they were using during their shift. The training topics included patient and family engagement, the components of the bedside shift report, the benefits and challenges of the bedside shift report, the impact of HIPPA on the bedside shift report, and the embedded training video (see AHRQ, 2014). The nursing staff were given 1 week to view the PowerPoint presentation prior to beginning the surveillance.

Data were collected through observation of the nursing staff during bedside report. Three questions were answered yes or no:

1. Was shift report conducted at the bedside?
2. Was the AHRQ bedside shift report checklist used?
3. Was the patient asked to participate in bedside reporting?

These questions were consistent with AHRQ's Guide to Engaging Patients and Families at The Bedside (Appendix F). I collected data through visual surveillance on the unit by standing at the patient's room door and observing the process and listening to the report. The surveillance was conducted over a 2-week period following the viewing of the PowerPoint presentation, the Guide to Engaging Patients and Families at The Bedside (Appendix G). I used the Bedside Reporting Surveillance Checklist and did not give it to the nursing staff (Appendix B). The Bedside Reporting Surveillance Checklist allowed me to determine whether the staff conducted bedside reporting as described in the

PowerPoint presentation (Appendix G). The nursing staff were informed via e-mail by the unit flight commander that surveillance would be conducted over a 2-week period after the PowerPoint presentation had been viewed. I viewed bedside reporting on the morning and evening shift change.

At the end of the 2-week surveillance period, I asked participants to complete the post-education and training survey (Appendix H). The letter and survey were left in the MSU break room (Appendices F and H). In the letter the nurses were asked to complete the post-education and training survey. The paper-and-pencil survey addressed the nursing staffs' perception of their level of satisfaction with bedside reporting practice following the PowerPoint presentation and the 2 weeks of conducting bedside reporting with the Bedside Shift Report Checklist (Appendix A) (Frazier & Garrison, 2014). Use of the Bedside Shift Report Checklist was presented in the Guide to Engaging Patients and Families at The Bedside (Appendices A and G). The paper-and-pencil survey and a collection box were left for 1 week in the staff break room to be completed at the nurses' leisure. The collection box was sealed with a label that was stamped over the box to indicate whether the seal had been broken. There were no identification numbers on the surveys because I was looking at the overall increase in satisfaction of the nurses and not the individual increases in satisfaction of bedside reporting.

Instruments

The Bedside Shift Report Checklist (Appendix A) was developed by the AHRQ (2014) to ensure that standardization in bedside reporting occurs from nurse to patient to nurse. The Bedside Shift Report Checklist was available through the AHRQ Guide to

Engaging Patients and Families at The Bedside section of the AHRQ website. The checklist was recommended for use by the AHRQ to ensure standardization from nurse to nurse, unit to unit, and hospital to hospital. The Bedside Shift Report Checklist included an introduction of the patient and family to the oncoming nurse, the use of the medical record at the bedside, SBAR reporting in terms the patient and family can understand, a focused assessment of the patient and a safety assessment of the room, a review of lab and test results, and identification of patient and family needs (AHRQ, 2014).

The Bedside Reporting Surveillance Checklist (Appendix B) allowed the surveyor, and in the future the unit leadership, to evaluate that staff are performing the practice correctly. The surveillance checklist included three questions that were to be answered by the observer either as a yes or no, and included the shift and date the surveillance occurred. The surveillance checklist will also help future evaluation and sustainment of the improved practice of bedside reporting.

The Bedside Reporting Pre-education and Training Survey (Appendix E), was adopted from the Timomen and Shivoen, (2000) survey. The survey had a four-point Likert scale using the alternatives of strongly agree, agree, disagree, and strongly disagree (Timonen & Sihvonen, 2000). The nurse rated each question of the survey either strongly agree, agree, disagree, and strongly disagree the following questions. The survey is composed of 4 topics and 25 questions with 3 areas identified as “other”. The topics included the nurses’ view of the aim of bedside reporting, patients’ activities in participating in the conversation during bedside reporting, bedside reporting, and factors that promote or prevent patient participation patient-centeredness (Timonen & Sihvonen,

2000). Permission has been obtained by John Wiley and Sons, Inc. on November 15, 2016 (Appendix I). The survey had been used by Leena Timonen and Marja Shivonen in their article *Patient participation in bedside reporting on surgical ward* published July 1, 2000 which was also used in four previous studies (Timonen & Sihvonen, 2000). Timonen and Shivonen (2000), had 118 participants who completed the survey. The Cronbach alpha is not reported. The pre- and post-education and training survey was solely in English with a letter explaining the purpose of the surveys.

Protection of Human Subjects

The D.N.P. student completed the National Institute of Health Office of Extramural Research web-based training course for Protecting Human Research Participants on March 11, 2014, certificate number1426444. The project was approved by the 673rd Medical Group Chief Nurse Executive, MSU Flight Commander and the MSU clinical nurse specialist. In addition, approval was obtained from the Institutional Review Board (IRB) of Walden University. The data was collected with no participant identifiers to protect the identity of those who completed the pre- and post-training surveys, as well as the bedside reporting surveillance checklist. The pre- and post-training surveys were voluntary. Conducting bedside reporting is mandatory as the nursing staff have been ordered by the nursing leadership. Completing the survey is not mandatory, but staff are highly encouraged by the leadership to participate. The pre- and post-education and training surveys was not identified with a specific participant, as the project was looking at an overall increase in satisfaction and use of the new practice. The bedside reporting

surveillance was only used to identify whether or not bedside reporting is being conducted in accordance with the PowerPoint presentation.

After completing the pre-and post-education surveys and training the participants placed the completed surveys in a sealed box that contains a deposit slot for the survey. The sealed box was stored in the nurses' break room for one week. Hard copies of the data are stored in a locked cabinet in the project leader's home office. There is also an electronic version of the data that is stored in the team leader's personal laptop. The laptop is password protected, as is the file that the project data is stored in. The team leader for the project is the only person to have access to the data.

Data Analysis

The data analysis used frequency and percentages to identify the changes between the questions of the pre- and post-education surveys (Appendices E and H). The change between the pre- and post-education and training survey results are displayed as a percentage. The data from the bedside reporting surveillance checklist is in the form of yes and no responses was evaluated examining the frequency of use of the bedside reporting practice following the viewing of the PowerPoint presentation (Appendix B). The data was will be entered into an Excel spreadsheet. Since this data was quantitative, the data was displayed in frequencies and percentage of responses to each Likert scale response.

Project Evaluation Plan

The framework for the project, Bedside Reporting: Improving Practice, used is the Plan-Do-Study-Act (PDSA) model. The model is widely used by AHRQ for

improving quality and patient safety (AHRQ, 2015). This model helped to ensure an systematic approach in evaluating the effectiveness of the implemenation of the project. The PDSA model use is also encouraged by the Institute for Healthcare Improvement (IHI), Cambridge, Massachusetts as a widely used model by hundreds of healthcare organizations (IHI, 2017). A PDSA worksheet provided by IHI was used in preparation to implementation of the project (Appendix J). The PDSA model allowed the project learder to explan to the nursing staff what the project was trying to accomplish, what the criteria is for determining if the change has made an improvement, and what changes were made to ensure improvement (AHRQ, 2015). The PDSA model can also be used the the rapid cycle format to ensure that improvement continues to ensure success (Kelly & Tazbir, 2014).

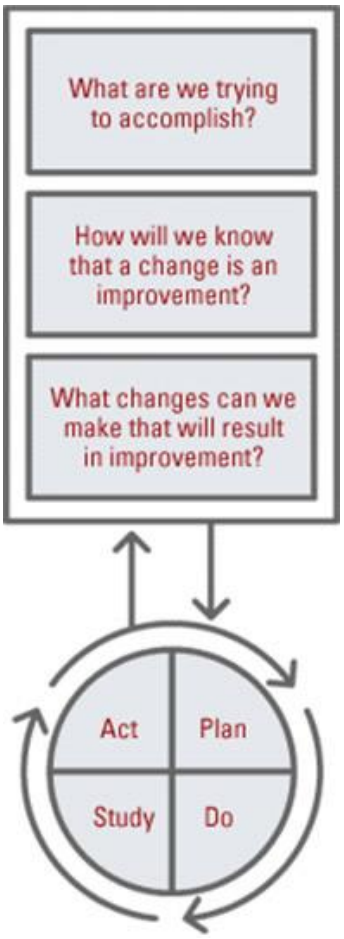


Figure 2. PDSA model.

Summary

Section three discussed the process that was used for the improvement project, Bedside Reporting: Improving the Practice. The population was the nursing staff at a large military hospital in Alaska. The education and training component of the project used the AHRQ developed education and training PowerPoint presentation with embedded training video, Guide to Engaging Patients and Families at the Bedside (Appendix G) (AHRQ, 2010). The goal of the project was to improve the practice of bedside reporting as demonstrated in the AHRQ, Guide to Engaging Patients and

Families at the Bedside embedded video. The pre- and post-education and training survey identified if nurses attitude toward the practice had improved, in addition to the nurses practice of bedside reporting. Frequency was used to analyze the data of the surveys. The project continued for a total of five weeks, with one week for each the pre- and post-education and training survey, one week to view the PowerPoint presentation, and two weeks of surveillance.

Several tools were used during the project; Bedside Reporting: Improving the Practice, which included the bedside shift report checklist (Appendix A), Bedside reporting surveillance checklist (Appendix B), and Bedside Reporting Pre- and Post-education and Training Survey (Appendices E and H). The pre- and post- education and training survey (Appendices E and H) had been used previously by Leena Timonen and Marja Shivonen in their article *Patient participation in bedside reporting on surgical ward* published July 1, 2000 which was also used in four previous studies. The Bedside shift report checklist (Appendix B) had been recommended for use by AHRQ, Guide to Engaging Patients and Families at the Bedside (AHRQ, 2014). The model for the evaluation plan was the PDSA model for process improvement, which was recommended for use by AHRQ and the IHI (AHRQ, 2015; IHI, 2017).

Section 4: Discussion and Implications

The purpose of the project was to improve the practice of bedside reporting through education and training. The education and training were conducted though a PowerPoint presentation with an embedded training video titled Guide to Patient and Family Engagement (Appendix G). The AHRQ developed a standardized tool to use during bedside reporting, called the Bedside Shift Report Checklist (Appendix A). During the project implementation, the nursing staff completed a pre- and post-education and training survey (Appendices F and H) to identify their satisfaction with bedside reporting before and after the Guide to Patient and Family Engagement PowerPoint (Appendix G). In addition, bedside reporting surveillance was conducted using the Bedside Reporting Surveillance Checklist after the nursing staff viewed the Guide to Patient and Family Engagement (Appendices B and G). Section 4 includes the results of the DNP project, an interpretation of the results in the context of the literature, the framework, recommended policy changes, self-analysis, and strengths and weakness of the project.

Summary and Evaluation of Findings

The purpose of the DNP project was to improve the practice of bedside reporting on the MSU. The project question was the following: Will computer-based training on the importance of and method to conduct bedside reporting as well the use of a standardized bedside reporting checklist increase the rate of bedside shift-to-shift reporting among nurses in the MSU to 100%? The practice initiative had three objectives. The first was to modify the AHRQ PowerPoint presentation to meet the specific needs of

the MSU. The second objective was that 100% of the MSU nursing staff would use a standardized tool (the AHRQ Bedside Shift Report Checklist) to perform the bedside shift-to-shift report (Appendix A). The third objective was to determine whether, after training, the MSU nursing staff would conduct bedside shift-to-shift reporting at a rate of 100% as evaluated by the MSU Bedside Reporting Surveillance Checklist (Appendix B). Statistical analysis was conducted using IBM SPSS Version 23 downloaded from Walden University's Center for Research Quality (Laureate Education, 2017). The data were analyzed using frequencies.

Objective 1: Modify the AHRQ PowerPoint

The MDG required that their logo be placed on the PowerPoint presentation. Some slides were removed because they did not pertain to the military hospital setting. The slides that were removed were more applicable to face-to-face training because they included role-playing exercises. The full PowerPoint presentation from AHRQ was submitted to the MDG patient safety officer who added the role-playing activities that were included in AHRQ's unmodified training to all MDG nursing staff to augment the TeamSTEPPS training. The PowerPoint presentation was e-mailed to all MSU nursing staff by the MSU flight commander. The nurse manager verified that the MSU nursing staff had viewed the PowerPoint in the 1-week time period.

Objective 2: 100% of MSU Nursing Staff Will Use the AHRQ Checklist

During the first week of the 2 weeks of surveillance, only three nurses used the AHRQ Bedside Shift Report Checklist (Appendix A). Several nursing staff were heard using elements of the checklist, but the checklist was not visible and several elements

were left out. In addition, during that first week all but two shift reports were conducted outside the door of the patient's room. During the second week of surveillance, 43 nurses used all elements of the Bedside Shift Report Checklist. The actual checklist was not visible to me; however, all elements of the checklist were included in the bedside shift report, whether the report was conducted in the room at the patient's bedside or outside the door of the patient's room A summary of checklist use is presented in Table 2.

Table 2

AHRQ Standardized Checklist Was Used

	Week 1 observed	Week 2 observed	Total observed
Inside of room	3	43	46
Outside of room	47	7	54
Total	50	50	100

Objective 3: Determine Whether all MSU Nursing Staff Will Conduct Bedside shift reporting

Bedside reporting surveillance was conducted using the Bedside Reporting Surveillance Checklist (Appendix B). The surveillance was conducted on the evening shift. During the first week of surveillance, I observed 50 shift reports, with most shift reports being conducted at the door of the patient's room and only two being conducted at the bedside. Another 50 observations of bedside shift reporting were completed during the second week of surveillance. The data collected during the second week showed that 43 of the shift reports were conducted at the bedside as the staff had been trained to do in

the Guide to Patient and Family Engagement PowerPoint (Appendix G). Shift report data are presented in Table 3.

Table 3

Shift Report was Conducted at the Bedside

	Week 1 Observed	Week 2 Observed	Total Observed
Inside of room	2	43	45
Outside of room	48	7	55
Total	50	50	100

Of the100 observations, only 44 patients/families were asked to participate. The participation of patients and families occurred almost exclusively in the second week of surveillance, as shown in Table 4. During the first week, the nursing staff did not conduct bedside reporting in the patient's room. During the second week, 42 patients and families participated in bedside reporting, and many patients and family members thanked the nurses for reporting at the bedside.

Table 4

Patient Was Asked to Participate in Bedside Report

	Week 1 Observed	Week 2 Observed	Total Observed
Inside of room	2	42	44
Outside of room	48	8	56
Total	50	50	100

Another aspect of Objective 3 was to determine whether nurses' attitudes

regarding bedside reporting prior to the DNP project changed after the education and training. The intent was to discover whether the education and training improved the practice or whether a change in attitude also helped improve the practice. The nursing staff prior to the project were conducting bedside shift-to-shift reports outside of the patient's room. There were 12 respondents who completed the pre-education and training survey (Appendix F), and 10 respondents who completed the post-education and training survey (Appendix H). Following the survey design used by Timonen and Sihvonen (2000), I used a 4-point Likert scale for responses in the surveys. The responses were combined into two categories (strongly agree and agree, and disagee and strongly disagree) (see Timonen & Sihvonen, 2000).

First, the nurses indicated whether they viewed the aim of bedside reporting as information for the nurse, for the patient, for both the nurse and patient, or for other. The 12 nurses who completed the preeducation and training survey responded to more than one of the aims. The nurses agreed that the aim of bedside reporting was for information for both the nurses and patients. In the post-education and training survey, two nurses responded to more than one aim. Data are presented in Table 5.

Table 5

Nurses' View of the Aim of Bedside Reporting

Aim	Pre-education and training survey	%	Post-education and training survey	%
1. Information for nurses	12	100	4	40
2. Information for the patient	10	83	4	40
3. Information for both nurses and patients	12	100	4	40
4. Other	0	0	0	0
N= Nurses who completed survey	N=12		N=10	

Prior to the education and training on bedside reporting, the nurses were not conducting bedside reporting in accordance with the Guide to Patient and Family Engagement PowerPoint (Appendix G). In the post-education and training survey, two nurses responded to more than one aim. The data showed that 40% of the nurses reported that bedside reporting was for the nurse, and 40% of the nurses responded that the information was for the patients. Lastly, 40% of the nurses responded that bedside reporting was for both the nurses and patient. The data from the post-education and training showed that 60% no longer felt the aim of bedside reporting was information for both the nurse and patient as compared to the pre-education and training survey.

The nurses in the pre-and post-education and training survey also responded to more than one aim of the nurses' description of communication during bedside reporting. Both nurses agreed in the pre- and post-education and training surveys that at least 60% of the time one nurse speaks while the others listen. In the pre-education and training survey, 58% of the respondents indicated that nurses speak mostly to themselves, while in the post-education and training survey, 50% indicated that this occurs. In response to

Question 3, 41% of respondents in the pre-education and training survey indicated that both nurses and patients take part in the conversation, whereas 50% indicated the same in the post-education and training survey. Significant improvement was identified with the question regarding patient talks and others listen. In the pre-education and training surveys 50% of respondents stated this occurred, and in the post-education and training surveys 100% of respondents stated this occurs. Data are presented in Table 6.

Table 6

Nurses' Description of Communication During Bedside Reporting

Aim	Pre-education and training survey	%	Post-education and training survey	%
1. Mainly one nurse speaking, others listening	7	58	6	60
2.Nurses speaking mostly to themselves	7	58	5	50
3. Both nurses and patients taking part in conversation	5	41	5	50
4. Patient talks, others listen	5	50	10	100
5. Other	0	0	0	0
N= nurses who completed a survey	N=12		N=10	

Once again to the question, patients actively participated in the conversation during bedside reporting, the respondents responded to more than one of the possible questions. The results of both the pre-and post-education and training survey identified that sometimes the patients actively participate in the conversation during bedside reporting (Table 7). In the post-education and training survey the nurses appeared to feel that patients were more participatory than in the pre-education and training survey.

Table 7

Patient Actively Participates in the Conversation During Bedside Reporting

Aim	Pre-education and training survey	%	Post-education and training survey	%
1. Always	2	16.7	5	50
2. Often	4	33	5	50
3. Sometimes	10	83	10	100
4. Not at all	1	8.3	5	50
N= nurses who completed a survey	N=12		N=10	

The results were identified from the question Bedside reporting; factors that promote or prevent patient participation identify the real improvement in the bedside reporting and identified the nurses concern about privacy. The pre-education and training survey was completed while the nurses were performing bedside reporting outside the patient's room door. The nurses identified in the pre-education and training survey that 91.67% feeling that privacy was ensured when they conducted bedside reporting at the patient's room door, as compared to the 50% who felt privacy was ensured when conducted at the bedside (Table 8).

The data shows an overall improvement in the patient participation and the factors that promote or prevent from the pre-education and training survey to the post-education and training survey. The nurses felt more that the presence of other patients does disrupt participation. The nurses identified that new practice hindered the discussion of very personal matters, from 58.33% in the pre-education and training survey to 100% in the post-education and training survey (Table 8). The nurses in the pre-education and training survey felt that their current practice of bedside of reporting was an appropriate use of

time. In the post-education and training survey the nursing staff felt that the improved practice of bedside reporting was not an effective use of their time.

Table 8

Bedside Reporting: Factors That Promote or Prevent Patient Participation

Aim	Pre-education and training survey	%	Post-education and training survey	%
1. Patient encouraged to ask questions	3	25	10	100
2. Nurses concentrate too much on patient documents	0	0	0	0
3. Privacy is ensured	11	91.67	5	50
4. Presence of other patients does not disturb	3	25	0	0
5. Relatives may participate	12	100	10	100
6. Too many members of staff taking part in reporting	0	0	0	0
7. Nurses are too far from patient's bed	7	58.33	0	0
8. No discussion of very personal matters	7	58.33	10	100
9. Nurses use medical jargon	9	75	1	10
10. Patient understands enough of the conversation	11	91.67	10	100
11. Patient hears the conversation well enough	6	50	10	100
12. Appropriate use of time	12	100	0	0
13. Too little time for each patient	3	25	0	0
N= nurses who completed a survey	N=12		N=10	

Discussion of Findings in the Context of Literature

The findings are consistent with Timomen and Sihvonen (2000), in that the nurses thought they understood the aim of the bedside reporting prior to the bedside reporting education and training (Table 6). The nurses' knowledge and skills of bedside reporting

after training did improve. However, the nurses' attitude about the practice of bedside reporting did not improve. The nurses' lack of change in attitude may be due to the resistance of the practice prior to the AHRQ bedside reporting education and training (Appendix G). The nursing staff "also listening to patients when the patient speaks" improved from the pre-education and training survey to the post-education and training survey (Appendices F and H). The project findings are also inconsistent with Timomen and Sihovnen (2000), as "only the patient speaks" is not the sole aim of bedside reporting. The aim of bedside reporting is for both patient/family and nurses to be actively involved in bedside reporting, however, in the project the nurses started listening to the patients more and including them in the bedside reporting process as observed during the surveillance process (Table 4).

Factors that promote or prevent patient participation in bedside reporting were not examined by Timomen and Sihvonen (2000) in a pre- and post-education and training context, but rather a patient versus nurse context. Timomen and Sihvonen (2000), found that the nurses more than the patients were concerned about privacy. In the project the nurses felt that privacy related to bedside reporting post-education and training prevented patient participation (Table 8). Both the Timomen and Sihvoven (2000) study and the project data showed that the nurses also felt that bedside reporting prevented the discussion of very personal matters (Table 8).

The PDSA framework used allowed identified changes that needed to be made with the survey if the project were to be repeated. The PDSA cycle worked well in that it allowed thorough planning and implementation of the project, studying the project

through surveillance, and acting on the observation discoveries by discussing findings with the CNO, flight commander, CNS, and nursing staff. Using PDSA model is already used by the organization and will allow for them to make changes necessary to continue to improve on the MSU nursing staffs' bedside reporting practices.

Implications

Policy

Bedside reporting is a practice that is gaining support from hospitals nation-wide as it increases patient satisfaction and reduces medical errors (Jeffs, et al., 2013). The policy for the MSU should be a continued practice of reporting at the bedside and not outside the patient's room. Patients fear being spoken about without being present for the conversation (Condon, 2008). Standing outside the room and giving nurse to nurse shift report validates that fear of being talked about, as the patient is now just out of ear shot. The MSU should implement the improved practice of bedside reporting in their unit orientation and role modeled by the new nurses preceptor. Role modeling the AHRQ bedside reporting technique aligning with the education and training powerpoint will help to set the standard for all new nursing staff (Appendix G) (Blumberg, 2009). All MSU staff receive initialTeamSTEPPS training and annual refresher TeamSTEPPS training. The Guide to Patient and Family Engagement should also be added to the initial and annual TeamSTEPPS training (Appendix G).

Practice

The MSU nursing staff during observations, were receiving a shift report as a group in the report room and then were leaving the reporting room and each nurse

receiving an individual nurse to nurse report at either the nurses' station or at the patient's room door. The door in some instances was open, allowing for the possibility for the patient to hear portions of the report. The nurses would then go into the room and the nurse going off shift would introduce the patient to the oncoming nurse, and then they would leave the room and repeat the process with the next patient.

In the improved practice of bedside reporting, as the demonstrated in the training video from AHRQ, the nurses would still receive a group shift report in the report room as they were prior to the improved practice (Appendix G). The oncoming nurse would then pair off with the nurse that had had their patient or patients and would go straight to the patient's room and to the bedside and give report. The nurses would ask the patient and family if they had any questions, then leave the room and proceed to the next patient. The improved practice of bedside reporting as demonstrated in the video by AHRQ appeared quicker as the nurses were no longer standing outside the door then proceeding to the room for patient nurse introductions (Appendix G). The nursing staff were also able to do a quick visual assessment and check medical equipment, such as an intravenous line. The quick focused assessment allowed for prioritization patients (Jeffs, et al., 2013). In the event the patient was asleep, the nurses would give report outside the patient's room with the door closed.

Bedside reporting surveillance will need to be continued by charge nurses or the nurse manager with the support of MSU leadership, and MDG executive leadership for sustainability of the improved practice (Timonen & Sihvonen, 2000). The nursing staff will need to be held accountable if they do not follow the standard of practice. Nursing

accountability for the improved practice of bedside reporting will take more effort on the part of the MSU leadership as they will need to be present during shift report on occasion to verify the practice continues (Baker, 2010). The charge nurses, patient safety officer, or nurse manager should use the MSU bedside reporting surveillance checklist to monitor the quality of bedside reporting (Appendix B).

Research

Future research on the topic of bedside reporting should also include how many medical errors or near misses have been identified during bedside shift report. Most research mentions that medical errors and near misses may be indentified, but not on average how many and what types are identified (Baker, 2010, Maxson, Derby, Wrobleski, & Foss, 2012). Nurses need to see bedside reporting as a tool to prevent medical errors and catch errors before they get to the patient and not as a waste of time. In addition, one of the top three causes of medical errors is communication and by conducting beside reporting communication would drop from the top three reason for errors (The Joint Commission, 2014).

Social Change

The social change that occurred on the unit was a more knowledgeable patient population as the patients took a more active role in their care, which may result in better patient outcomes. In addition, communication between the patient/family and nurse was more of a partnership between the patient and the nurses. Communication that is patient- and family-centered care now shifts the power from the healthcare worker to the patient (Insitute for Patient- and Family-Centered Care, 2010). A patient engaged in their

healthcare is more likely to be compliant with their discharge instructions. Communication with the patient and family at the bedside opened communication channels from one way to two-way communication this is a small step that in a bigger picture can lead to a more knowledgeable, healthier, and more satisfied patient population may increase healthcare literacy and decrease hospital admissions and readmissions.

Strengths and Limitations of the Project

Strengths

The strength of the DNP project was having the support of the MDG's nursing leadership. The MDG leadership allowed for a location for survey distribution and collection, and emailing the Guide to Patient and Family Engagement PowerPoint to the nursing staff (Appendix G). The leadership also allowed for surveillance to be conducted on the unit. Another strength was use of the program developed by AHRQ, Engaging the Patient and Family at the Bedside (AHRQ, 2014). The AHRQ has all the tools need for an organization to implement bedside reporting, including patient information pamphlets, an education and training PowerPoint, and the bedside reporting checklist (Appendices A and G) (AHRQ, 2014).

Limitations

There were three limitations identified during and after the project. First, MSU leadership and hospital executive leadership were not present during shift change. The nurses who are responsible for ensuring nursing accountability for bedside reporting have been nurses for two to four years. The charge nurses are responsible for holding their peers accountable for conducting bedside reporting, which may place sustainability of the

practice in question. In addition, I am a civilian with little influence over the military nursing staff. Little influence by civilians over military personnel and peers holding each other accountable for the improved bedside reporting practice make it even more important for the MDG nursing leadership to support the practice with their presence.

The second limitation of the project that was identified during the analysis of the data was the pre- and post-education and training survey. Future surveys using Timomen and Sihvonen (2000), should be modified to allow one response per section. By only allowing for one response per section the nurses would not be able to respond multiple times, as an example, the nurses made multiple responses to what they thought the goal of bedside reporting was (Table 5).

The third limitation was not imposing on the patients as surveillance was conducted at the door and not in the room with the nurses and patients. Conducting surveillance outside the room prevented disruption in the bedside reporting process. The difficulty with conducting surveillance at the door was that there was difficulty in hearing the nursing staff to ensure they met all the criteria of the bedside reporting checklist (Appendix A).

Recommendations

It is recommended to have a more visible nursing leadership during bedside shift report. The presence of nursing leadership, as for example, the CNO, CNS, and flight commander, will show their support not only for the process, but also provide support to the charge nurses who will be holding staff accountable for the practice of bedside reporting. Another recommendation is that the charge nurse conducts bedside reporting

surveillance and reports the data collected at the MSU staff meeting, nurse executive counsel and to the patient safety officer. Presenting data on bedside reporting will help with sustainability (Baker, 2010, Jeffs, et al., 2013).

The final recommendation would be that the MDG include the questions related to bedside reporting into the patient satisfaction surveys for those patients discharged from the MSU. The MDG does not participate in Hospital Compare tool that is on the Centers for Medicare for Medicaid Services website because they are a federal facility, however, the MDG can still compare their patient satisfaction rating on "Patients who "Strongly Agree" they understood their care when they left the hospital" with three of the local hospitals (CMS, 2017). The local hospitals rating of "Patients who "Strongly Agree" they inderstand their care when they left the hosptial; hospital A- 51%, hospital B- 49%, hospital C- 53%, Alaska average- 49%, and national average- 52% (CMS, 2017). The MDG with the improved practice bedside reporting should be able to meet or exceed the Alaska and national average.

Analysis of Self as Scholar

Over the course of the DNP program and my Masters education at Walden University, I have developed a more critical eye, when it comes to research and processes. The DNP project is an example of scholarship and examining the EBP critically. I now understand the true importance of scholarship for the Masters and Doctoral prepared nurse to advance the profession of nursing for better patient outcomes, safer nursing practice, and improved patient and nursing satisfaction (DNP Essentials Task Force, 2006). I have long understood that change for the sake of change is not good,

however, looking for opportunities to improve process is now something that comes more naturally.

Analysis of Self as Practitioner

I have looked for opportunities in the nursing education setting as well as the hospital setting for areas that can be improved to provide for better patient outcomes. As a nurse educator, I have ensured that bedside reporting was taught to my nursing students in the clinical setting so that as new nurses are trained in nursing school to ensure that bedside reporting will not be a foreign or fearful concept to the nursing student. In addition, I explain to the students that bedside reporting is also a way to provide education to patients about the health care to improve patient outcomes once the patient is discharged from the hospital.

Also, as a nursing director of an LPN, ADN, and BSN program, understanding the importance of scholarship for the faculty is significant. I have worked as an instructor in an ADN program which did not support scholarship and expected faculty to develop scholarship after work hours, even though the program wanted credit for the scholarship that was completed by their faculty. Scholarship lagged in that program. As nursing leader, I want my faculty to understand that I support scholarship activities and their hours on their door schedules that relate to other professional activities will be supported. Nurses should examine nursing education, professional activities, and scholarship as ways to advance the profession of nursing, conduct research, and disseminate EBP to improve healthcare outcomes (AACN, 1999).

Analysis of Self as Project Developer

Project development was challenging, as it was not an instance where I implemented already developed military policy as directed by military leadership's plan. I have always been a person who did not believe in recreating the proverbial wheel, but rather conduct a review and find EBP and making modifications to fit my needs. Development of the project necessitated a lot of time reading journal articles to find what has worked and what has not worked related to the implementation and sustainment of bedside reporting. I have not done such a in depth review and critique of journal articles for a project before. I was able to learn from those who had previously conducted research on bedside reporting, through scholarly review, helped to eliminate those pitfalls they faced when implementing bedside reporting.

I also found the value in understanding change theory, specifically Havelock's change theory (Kelly & Tazbir, 2014). I was an outsider to the area where my project was implemented and I had to develop relationships and gain the trust of nursing staff to ensure their participation in the project. Change does not occur because the project leader wanted it to, but rather by a process such as Havelock's theory of change. Understanding that change occurs once trust is obtained, the staff understand how they are benefited by the change, and once you get informal leaders to accept the change they will help to encourage others to accept the change (Kelly & Tazbir, 2014). I know there will be early adopters, and the laggards to change and I understand now the importance of identifying those people to ensure the change occurs (Kelly & Tazbir, 2014).

Future Professional Development

After completion of the DNP program, I plan on looking for an adult-geriatric nurse practitioner certificate program. I feel that this is an area that of my nursing career I would like to develop. A better understanding of all levels of nursing will help me to be a better nurse leader, as well as give me more career options, if I return to providing direct patient care, such as working for the VA or military health facility. Until I find the best program for my needs, I will be looking to obtain a certification as a nurse executive. As a certified nurse executive, I will be validating my knowledge and expertise in the leadership and management arena. I am currently taking a yearlong leadership course to learn more about community college education in Florida and improve my leadership skills as a new director of nursing. The leadership course also helps to strengthen leadership skills I have learned through this program. The goal is to give me tools to help my faculty improve the education they provide to their students.

Summary and Conclusions

The DNP project Bedside Reporting: Improving practice did not improve the MSU staffs' satisfaction with the process of bedside reporting, but it did allow for a better understanding of the process. During the second week of surveillance, 43 of the 50 observations identified that the MSU nursing staff were conducting bedside reporting as demonstrated in the AHRQ training video, which was a rate of 86%. The project goal of 100% was not met, however the rate of bedside reporting increased from 0% to 86%, which is a significant improvement.

The project recommendations included support and surveillance for continued sustainability (Jeffs, et al., 2013). The DNP project has strengthened my knowledge, tools and skills set as a scholar, as a practitioner, and as a project developer. Advancing the profession of nursing for improved patient outcomes can occur in many ways, one of which is supporting nursing faculty in the professional advancement which will also reflect in the classroom on future nurses. Finally, advancing my knowledge as a nurse through continuing my nursing education. Nurses are lifelong learners and DNPs should be the purest refection that nurses never stop learning.

Section 5: Scholarly Product

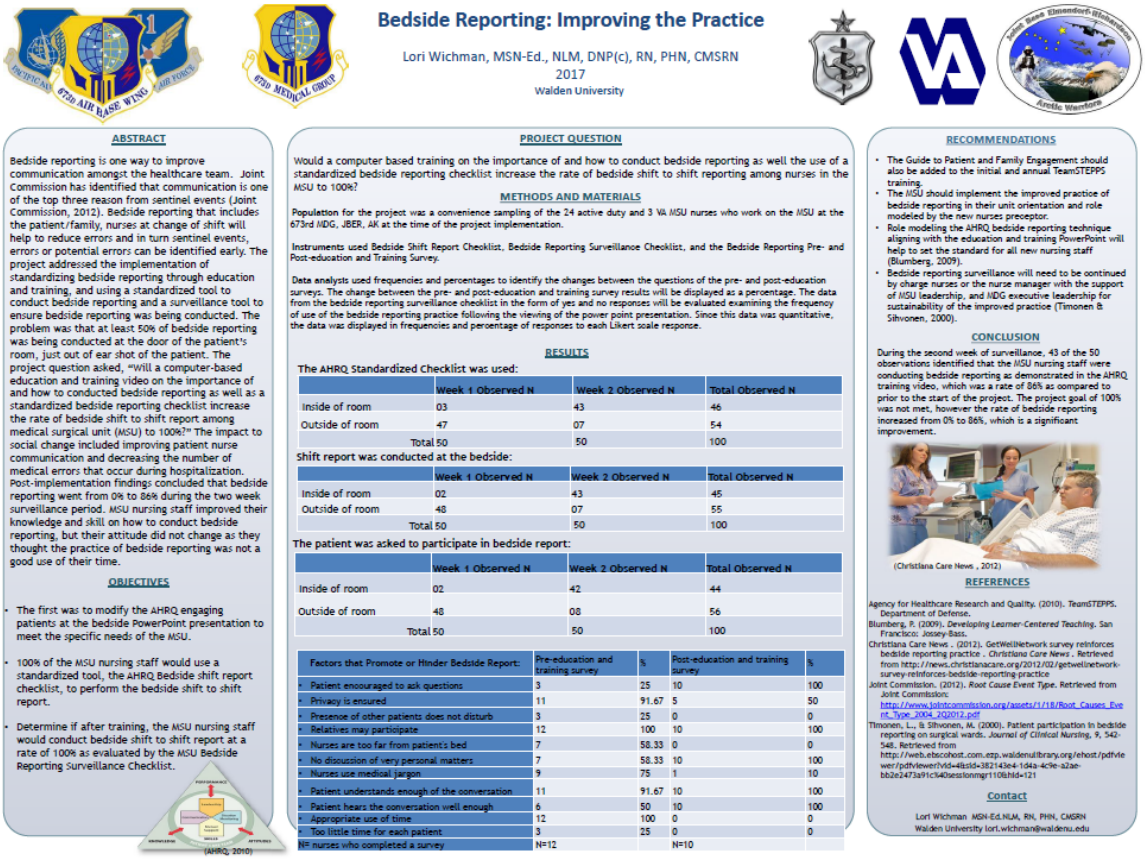
Dissemination of information at the end of a process improvement is a crucial component of any process that has been implemented. Dissemination allows those who were involved in the process improvement to understand the impact of the process improvement and whether the process is worth continuing or changing (Kelly & Tazbir, 2014). For the project Improving Bedside Reporting Practice, the organization decided to continue with the improved process and conduct a rapid cycle PDSA to improve the practice of bedside reporting to better meet the needs of their patient population. Section 5 includes a discussion of the scholarly product, a poster presentation, to disseminate the results of the project.

Poster Presentation

A poster presentation was an appropriate way to disseminate information to the nursing staff on the MSU. An e-mail with a PowerPoint Presentation may not have been reviewed by the nursing staff. The poster was placed in the nurses' break room and on the MSU bulletin board by the unit flight commander or the chief nurse. The poster was delivered to the chief nurse, and a teleconference with key stakeholders was scheduled to discuss the findings of the project and answer any questions.

The poster is 36 by 48 inches and includes information on the abstract, project objectives, project question, methods and materials, results, recommendations, conclusions, references, and how to contact me for future questions. The poster also contains the airbase wing emblem, the MDG emblem, the Air Force senior nurses badge, the VA logo, and the joint base logo. The color and format of the poster are professional

and consistent with previous Air Force poster presentations at the facility, as shown in Figure 3.



Bedside Reporting: Improving the Practice

Lori Wichman, MSN-Ed., NLM, DNP(c), RN, PHN, CMSRN
2017
Walden University

ABSTRACT

Bedside reporting is one way to improve communication amongst the healthcare team. Joint Commission has identified that communication is one of the top three reason from sentinel events (Joint Commission, 2012). Bedside reporting that includes the patient/family, nurses at change of shift will help to reduce errors and in turn sentinel events, errors or potential errors can be identified early. The project addressed the implementation of standardizing bedside reporting through education and training, and using a standardized tool to conduct bedside reporting and a surveillance tool to ensure bedside reporting was being conducted. The problem was that at least 50% of bedside reporting was being conducted at the door of the patient's room, just out of ear shot of the patient. The project question asked, "Will a computer-based education and training video on the importance of and how to conducted bedside reporting as well as a standardized bedside reporting checklist increase the rate of bedside shift to shift report among medical surgical unit (MSU) to 100%?" The impact to social change included improving patient nurse communication and decreasing the number of medical errors that occur during hospitalization. Post-implementation findings concluded that bedside reporting went from 0% to 86% during the two week surveillance period. MSU nursing staff improved their knowledge and skill on how to conduct bedside reporting, but their attitude did not change as they thought the practice of bedside reporting was not a good use of their time.

OBJECTIVES

- The first was to modify the AHRQ engaging patients at the bedside PowerPoint presentation to meet the specific needs of the MSU.
- 100% of the MSU nursing staff would use a standardized tool, the AHRQ Bedside shift report checklist, to perform the bedside shift to shift report.
- Determine if after training, the MSU nursing staff would conduct bedside shift to shift report at a rate of 100% as evaluated by the MSU Bedside Reporting Surveillance Checklist.

(AHRQ, 2010)

PROJECT QUESTION

Would a computer based training on the importance of and how to conduct bedside reporting as well the use of a standardized bedside reporting checklist increase the rate of bedside shift to shift reporting among nurses in the MSU to 100%?

METHODS AND MATERIALS

Population for the project was a convenience sampling of the 24 active duty and 3 VA MSU nurses who work on the MSU at the 673rd MDG, JBER, AK at the time of the project implementation.

Instruments used Bedside Shift Report Checklist, Bedside Reporting Surveillance Checklist, and the Bedside Reporting Pre- and Post-education and Training Survey.

Data analysts used frequencies and percentages to identify the changes between the questions of the pre- and post-education surveys. The change between the pre- and post-education and training survey results will be displayed as a percentage. The data from the bedside reporting surveillance checklist in the form of yes and no responses will be evaluated examining the frequency of use of the bedside reporting practice following the viewing of the power point presentation. Since this data was quantitative, the data was displayed in frequencies and percentage of responses to each Likert scale response.

RESULTS

The AHRQ Standardized Checklist was used:

	Week 1 Observed N	Week 2 Observed N	Total Observed N
Inside of room	03	43	46
Outside of room	47	07	54
Total	50	50	100

Shift report was conducted at the bedside:

	Week 1 Observed N	Week 2 Observed N	Total Observed N
Inside of room	02	43	45
Outside of room	48	07	55
Total	50	50	100

The patient was asked to participate in bedside report:

	Week 1 Observed N	Week 2 Observed N	Total Observed N
Inside of room	02	42	44
Outside of room	48	08	56
Total	50	50	100

Factors that Promote or Hinder Bedside Report:	Pre-education and training survey	%	Post-education and training survey	%
Patient encouraged to ask questions	3	25	10	100
Privacy is ensured	11	91.67	5	50
Presence of other patients does not disturb	3	25	0	0
Relatives may participate	12	100	10	100
Nurses are too far from patient's bed	7	58.33	0	0
No discussion of very personal matters	7	58.33	10	100
Nurses use medical jargon	9	75	1	10
Patient understands enough of the conversation	11	91.67	10	100
Patient hears the conversation well enough	6	50	10	100
Appropriate use of time	12	100	0	0
Too little time for each patient	3	25	0	0
N= nurses who completed a survey	N=12		N=10	

RECOMMENDATIONS

- The Guide to Patient and Family Engagement should also be added to the initial and annual TeamSTEPPS training.
- The MSU should implement the improved practice of bedside reporting in their unit orientation and role modeled by the new nurses preceptor.
- Role modeling the AHRQ bedside reporting technique aligning with the education and training PowerPoint will help to set the standard for all new nursing staff (Blumberg, 2009).
- Bedside reporting surveillance will need to be continued by charge nurses or the nurse manager with the support of MSU leadership, and MDG executive leadership for sustainability of the improved practice (Timonen & Sihvonen, 2000).

CONCLUSION

During the second week of surveillance, 43 of the 50 observations identified that the MSU nursing staff were conducting bedside reporting as demonstrated in the AHRQ training video, which was a rate of 86% as compared to prior to the start of the project. The project goal of 100% was not met, however the rate of bedside reporting increased from 0% to 86%, which is a significant improvement.

(Christiana Care News , 2012)

REFERENCES

Agency for Healthcare Research and Quality. (2010). *TeamSTEPPS*. Department of Defense.

Blumberg, P. (2009). *Developing Learner-Centered Teaching*, San Francisco: Jossey-Bass.

Christiana Care News . (2012). GetWellNetwork survey reinforces bedside reporting practice . *Christiana Care News* . Retrieved from http://news.christianacare.org/2012/02/getwellnetwork-survey-reinforces-bedside-reporting-practice

Joint Commission. (2012). *Root Cause Event Type*. Retrieved from Joint Commission: http://www.jointcommission.org/assets/1/18/Root_Causes_Event_Type_2004_2Q2012.pdf

Timonen, L., & Sihvonen, M. (2000). Patient participation in bedside reporting on surgical wards. *Journal of Clinical Nursing*, 9, 542-548. Retrieved from http://web.ebscohost.com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=4&sid=382143e4-1d4a-4c9e-a2ae-bb2e2473a91c%40sessionmgr110&hid=121

Contact

Lori Wichman MSN-Ed.NLM, RN, PHN, CMSRN
Walden University lori.wichman@waldenu.edu

Figure 3. Poster presentation.

Summary

Creating a poster presentation to communicate new information is a wonderful way for the graduate level nurse to participate in the scholarship of teaching (AACN, 1999). The project included 12 nurses in the preeducation and training survey and 10 nurses in the posteducation and training survey. In addition, the project included 100 observations of patients and the nurses who were charged with their care. The project

improved the knowledge and skills of the nursing staff and improved the communication between the nursing staff and their patients.

The opportunity to develop and conduct a project at this level was an excellent way to apply all that was learned in the DNP program and put that knowledge into practice. The project allowed for participation in not only the scholarship of teaching, but also the scholarship of application and the scholarship of integration (AACN, 1999). As a project leader and a doctorally prepared nurse, I hope that patients who are impacted by this and future projects will experience improved health care outcomes.

References

Agency for Health Care Research and Quality. (n.d.). Retrieved from Patient Safety Network http://www.ahrq.gov/teamsteppstools/instructor/fundamentals/module1/igintro.htm#obj

Agency for Healthcare Research and Quality. (2010). *TeamSTEPPS.* Depertment of Defense.

Agency for Healthcare Research and Quality. (2014). Guide to patient and family engagement. Retrieved from http://www.ahrq.gov/research/findings/final-reports/ptfamilyscan/ptfamilysum.html

Agency for Healthcare Research and Quality. (2015). *Plan-Do-Study-Act (PDSA) directions and examples*. Retrieved fromhttps://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2-tool2b.html

American Association of Colleges of Nursing. (1999). Defining scholarship for the discipline of nursing. Retrieved from http://www.aacnnursing.org/News-Information/Position-Statements-White-Papers/Defining-Scholarship

American Institutes for Research. (2012). Guide to patient and family engagement: Environmental scan report. Retrieved from http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/final-reports/ptfamilyscan/ptfamilyscan.pdf

Anderson, C., & Mangino, R. (2006). Nurse shift report: Who says you can't talk in front of the patient? *Nursing Administration Quarterly, 30*, 112-122. Retrieved from http://journals.lww.com/naqjournal/Abstract/2006/04000/Nurse_Shift_Report__Who_Says_You_Can_t_Talk_in.8.aspx

Baker, S. J. (2010). Bedside shift report improves patient safety and nurse accountability. *Journal of Emergency Nursing, 36*(4), 355-358.

Bisnett, T. O. (2014). *673rd medical group FY15-19 business performance plan.* Joint Base Elmendorf Richardson.

Blumberg, P. (2009). *Developing learner-centered teaching.* San Francisco, CA: Jossey-Bass.

Boaro, N., Fancott, C., Baker, R., Velji, K., & Andreoli, A. (2010). *Using SBAR to improve communication in interprofessional rehabilitation teams.* Retrieved from

Brenowitz, R. S., & Manning, M. (2003). How leaders get buy-in. *Innovative Leader, 12*(2). Retrieved from http://www.winstonbrill.com/bril001/html/article_index/articles/551-600/article571_body.html

Burns, N., & Grove, S. K. (2009). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (6th ed.). St. Louis, MO: Saunders.

Centers for Medicare & Medicaid Services. (2017). *Hosptial compare*. Retrieved from https://www.medicare.gov/hospitalcompare/compare.html#cmprTab=1&cmprID=020001%2C020017%2C020006&cmprDist=3.6%2C5.4%2C48.3&dist=200&loc=99507&lat=61.148769&lng=-149.8010811

Christiana Care News. (2012). GetWellNetwork survey reinforces bedside reporting practice . Retrieved from http://news.christianacare.org/2012/02/getwellnetwork-survey-reinforces-bedside-reporting-practice

Condon, B. B. (2008). Feeling misunderstood: A concept analysis. *Nursing Forum, 43*(4), 177-190.

Cypress, B. S. (2011). Exploring the concept of nurse-physician communication within the context of healthcare outcomes using the evolutionary method of concept analysis. *Dimensions of Critical Care Nursing, 30*(1), 28-38.

D'avolio, L. (2015, October 15). *Healthcares Deadly Data Problem*. Retrieved from The Healtcare Blog: http://thehealthcareblog.com/blog/2015/10/26/healthcares-deadly-data-problem/

D'avolio, L. (2016, January 15). *Data Thinking In Health Care*. Retrieved from The Health Care Blog: http://thehealthcareblog.com/blog/2016/01/15/data-thinking-in-healthcare/

Dearmore, V., Roussel, L., Buckner, E., Mulekar, M., Pomrenke, B., Salas, S., . . . Brown, A. (2013). Transforming Care at the Bedside (TCAB): Enhancing Direct Care and Value-added care. *Journal of Nursing Management, 21*, 668–678. doi:10.1111/j.1365-2834.2012.01412.x

DNP Essentials Task Force. (2006, October). *The essentials of doctoral education for advance nursing practice*. Retrieved from The American Association of Colleges of Nursing (AACN): http://www.aacn.nche.edu/publications/position/DNPEssentials.pdf

DoD Patient Safety Program. (2015, September 1). *Patient Safety Spotlight: 673 MDG, JB Elmendorf-Richardson, Alaska.* Retrieved from Defense Health Agency: http://www.health.mil/News/Articles/2015/08/31/Patient-Safety-Spotlight-673-Medical-Group

Eggertson, L. (2012, May). On the same team? Nurse-Physician communication. *Canadian Nurse, 108*(5), 28-32. Retrieved from http://ehis.ebscohost.com.ezp.waldenulibrary.org/eds/pdfviewer/pdfviewer?vid

Enfinger, W., Garder, G., & Durant, C. (2013, January). Talk to Me: One facility's four year path to reducing reported patient safety events associated with poor communitcation. *MedSim, 2*(1), 12-14. Retrieved from MedSim: http://issuu.com/halldale/docs/medsim_1_2013?mode=embed&layout=http%3A%2F%2Fskin.issuu.com%2Fv%2Fcolor%2Flayout.xml&backgroundColor=FFFFFF&showFlipBtn=true

Evans, M. M. (2013). Bedside Reporting: Is it Enhancing Nursing Care? *Med-Surg Matters, 22*(5), 3. Retrieved from http://web.ebscohost.com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?sid=624339d7-65a3-4c2a-95c7-2751370852a9%40sessionmgr198&vid=4&hid=128

Forces of Magnetism. (2011, September 13). Retrieved from The American Nurses Credentialing Center: http://www.nursecredentialing.org/Magnet/ProgramOverview/ForcesofMagnetism.aspx

Frazier, J. A., & Garrison, W. (2014, April). Addressing Perceptions of Bedside Reporting for Successful Adoption. *Nurse Leader, 12*(2), 70-74. doi:10.1016/j.mnl.2013.09.013

Gonzalo, A. (2011). *Madeleine M. Leininger*. Retrieved from Theoretical Foundations of Nursing: http://nursingtheories.weebly.com/madeleine-m-leininger.html

IHI.org. (2017). *Plan-Do-Study-Act (PDSA) Worksheet*. Retrieved from Institute for Healtchare Improvement: http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

Institute for Patient- and Family-Centered Care. (2010, December 29). *Frequently asked questions*. Retrieved from Institute for Patient- and Family-Centered Care: http://www.ipfcc.org/faq.html

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

Joint Base Elmendorf-Richardson. (2014). *673d Medical Group*. Retrieved from Joint Base Elmendorf-Richardson: http://www.jber.af.mil/units/673dmedicalgroup/index.asp

Joint Commission. (2012). *Root Cause Event Type*. Retrieved from Joint Commission: http://www.jointcommission.org/assets/1/18/Root_Causes_Event_Type_2004_2Q 2012.pdf

Kelly, P., & Tazbir, J. (2014). *Essentials of nursing leadership and management* (3rd ed.). Cengage Learning.

Kritsonis, A. (2011, September 11). *Change Theory Kurt Lewin*. Retrieved from Nursing Theories: http://currentnursing.com/nursing_theory/change_theory.html

Laureate Education. (2017). *Research resources: SPSS*. Retrieved from Walden University Center for Research Quality: http://academicguides.waldenu.edu/researchcenter/resources/SPSS

Longenecker, C. &. (2014). Why Hospital Improvement Efforts Fail: A View From the Front Line. *Journal Of Healthcare Management, 59*(2), 147-157. Retrieved from http://web.a.ebscohost.com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=3&sid=8469cd9a-616c-4ec5-82db-b1c570f098b0%40sessionmgr4004&hid=4109

Malkowiak, J., & McConnell, K. (2014, April 3). *The Bedside Shift Report: Engaging Patients and Families as Partners.* Retrieved from EngagingPatients.org: http://www.engagingpatients.org/best-practices-and-methodologies/bedside-shift-report-engaging-patients-families-partners/

Maxson, P., Derby, K., Wrobleski, D., & Foss, D. (2012, May-June). Bedside nurse to nurse handoff promotes patient safety. *Medsurg Nursing, 21*(3), 140-145. Retrieved from http://ehis.ebscohost.com.ezp.waldenulibrary.org/eds/pdfviewer/pdfviewer?vid

McMurray, A., Chaboyer, W., Wallis, M., Johnson, J., & Gehrke, T. (2011). Patients' perspectives of bedside nursing handover. *Collegian, 18*, 19-26. doi:10.1016/j.colegn.2010.04.004

Minkoff, K., & Cline, C. (2004). *Philosophy, Process and Technique of Systems Change*. Retrieved from Continuous Quality Improvement and CCISC: http://www.hss.state.ak.us/dbh/system_redesign/print/Continuous%20Quality%20Improvement.pdf

Novak, K., & Fairchild, R. (2012). Bedside reporting and SBAR: Improving patient communication and satisfaction. *Journal of Pediatric Nursing, 27*, 760-762. Retrieved from http://web.ebscohost.com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?sid=b8aa2dc2-776c-4c4f-99f6-b692f04e76bf%40sessionmgr198&vid=16&hid=112

Nursing Theory. (2013). *Goal Attainment*. Retrieved from Nursing Theory: http://www.nursing-theory.org/theories-and-models/king-theory-of-goal-attainment.php

O'Daniel, M., & Rosenstein, A. H. (n.d.). *Chapter 33. Professional Communication and Team Collaboration.* Retrieved February 4, 2012, from Patient Safety and Quality; An Evidence-Based Handbook for Nurses: http://www.ahrq.gov/qual/nurseshdbk/docs/O'DanielM_TWC.pdf

Porter, P. A. (2015, September 2). Bedside Reporting at Alaska Native Medical Center. (L. Wichman, Interviewer)

Rabol, L., McPhail, M., Ostergaard, D., Andersen, H., & Mogensen, T. (2012). Promoter and barriers in hospital team communication. A focus group study. *Journal of Communication in Healthcare, 5*(2), 129-139. doi:10.1179/1753807612Y.0000000009

Rimmerman, C. M. (2013, May-June). Establishing Patient-Centered physician and nurse bedside rounding. *Physician Executive Journal* , 22-25. Retrieved from http://web.ebscohost.com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?sid=b8aa2dc2-776c-4c4f-99f6-b692f04e76bf%40sessionmgr198&vid=16&hid=112

Robinson, P. F., Gorman, G., Slimmer, L. W., & Yudkowsky, R. (2010). *Perceptions of Effective and Ineffective Nurse-Physician Communication in Hospitals.* Retrieved from Wiley Periodicals: http://web.ebscohost.com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?sid=b109a460-14ec-404a-95ce-d5bac636e323%40sessionmgr11&vid=15&hid=13

Salas, E., DiazGranados, D., Weaver, S. J., & King, H. (2008). *Does Team Training Work? Principles for Health Care.* Retrieved February 4, 2012, from http://web.ebscohost.com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?sid=1eb1a1ef-6e88-4b11-b40d-b16c4c8f8afd%40sessionmgr14&vid=6&hid=10

Slatore, C., Hansen, L., Ganzini, L., Press, N., Osborne, M., Chesnutt, M., & Mularski, R. (2012, November). Communication by Nurses in the intensive care unit: Qualitative anaylsis of domain of patient-centered care. *American Journal of Critical Care, 21*(6), 410-418. Retrieved from http://ehis.ebscohost.com.ezp.waldenulibrary.org/eds/pdfviewer/pdfviewer?vid

Stickney, C. A., Ziniel, S. I., Brett, M. S., & Truog, R. D. (2014, December). Family Participation during Intensive Care Unit Rounds: Goals and Expectations of Parents and Health Care Providers in a Tertiary Pediatric Intensive Care Unit. *The Journal of Pediatrics, 165*(6), 1245 - 1251.e1. Retrieved from http://dx.doi.org/10.1016/j.jpeds.2014.08.001

Subramony, A., Schwartz, T., & Hametz, P. (2012). Family-Centered rounds and communication about discharge between familie and inpatient medical teams. *Clinical Pediatrics, 51*(8), 730-738. doi:10.1177/0009922812446912

Tan, A. K. (2015, Jan-Apr). Emphasizing caring components in nurse-patient-nurse bedside reporting. *International Journal of Caring Sciences, 8*(1), 188-193. Retrieved from http://search.proquest.com.ezp.waldenulibrary.org/docview/1648623547

Terry, A. J. (2015). *Clinical Research for the Doctor of Nursing Practice* (2nd ed.). Burlington, Massachusetts: Jones and Bartlett Learning.

The Joint Commission. (2014, September 30). *Sentinel event data - Root causes by event type.* Retrieved from The Joint Commission: http://www.jointcommission.org/Sentinel_Event_Statistics/

Thomas, L., & Donohue-Porter, P. (2012, April-June). Blending evidence and innovation: Improving intershift handoffs in a multihospital setting. *Journal of Nursing Care Quality, 27*(2), 116-124. doi:10.1097/NCQ.0b013e318241cb3b

Timonen, L., & Sihvonen, M. (2000). Patient participation in bedside reporting on surgical wards. *Journal of Clinical Nursing, 9*, 542-548. Retrieved from

http://web.ebscohost.com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=4&sid=382143e4-1d4a-4c9e-a2ae-bb2e2473a91c%40sessionmgr110&hid=121

Trossman, S. (2009, March/April). Shifting to the bedside for report. *The American Nurse*, p. 7.

Tschannen, D., Schoville, R., Schmidt, P., Buehler, K., Borst, S., & Flaherty-Robb, M. (2013). Communication practices among nurses in the acute care setting. *Journal of Communication in Healthcare, 6*(3), 171-179. doi:10.1179/1753807613Y.0000000037

Wakefield, D., Ragan, R., Brandt, J., & Tregnago, M. (2012, June). Making the transition to nursing bedside shift reports. *The Joint Commission Journal on Quality and Patient Safety, 38*(6), 243-253. Retrieved from http://store.jcrinc.com/assets/1/14/S1-JQPS-0612_wakefield.pdf

Weaver, S. J., Rosen, M. A., Salas, E., Baum, K., & King, H. B. (2010). *Intergrating the Science of Team Training: Guidelines for Continuing Education.* Retrieved from http://web.ebscohost.com.ezp.waldenulibrary.org/ehost/pdfviewer/pdfviewer?vid=3&hid=10&sid=1eb1a1ef-6e88-4b11-b40d-b16c4c8f8afd%40sessionmgr14

Appendix A: Bedside Shift Report Checklist

Bedside Shift Report Checklist

- ❑ Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report.
- ❑ Open the medical record or access the electronic work station in the patient's room.
- ❑ Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.
  - **S** = **Situation**. What is going on with the patient? What are the current vital signs?
  - **B** = **Background**. What is the pertinent patient history?
  - **A** = **Assessment**. What is the patient's problem now?
  - **R** = **Recommendation**. What does the patient need?
- ❑ Conduct a focused assessment of the patient and a safety assessment of the room.
  - Visually inspect all wounds, incisions, drains, IV sites, IV tubings, catheters, etc.
  - Visually sweep the room for any physical safety concerns.
- ❑ Review tasks that need to be done, such as:
  - Labs or tests needed
  - Medications administered
  - Forms that need to be completed (e.g., admission, patient intake, vaccination, allergy review, etc.)
  - Other tasks: _____
- ❑ Identify the patient's and family's needs or concerns.
  - Ask the patient and family:
    - *"What could have gone better during the last 12 hours?"*
    - *"Tell us how your pain is."*
    - *"Tell us how much you walked today."*
    - *"Do you have any concerns about safety?'*
    - *"Do you have any worries you would like to share?"*
  - Ask the patient and family what the goal is for the next shift. This is the patient's goal — not the nursing staff's goal for the patient.
    - *"What do you want to happen during the next 12 hours?"*
    - Follow up to see if the goal was met during the verbal SBAR at the next bedside shift report.

Adapted from the Emory University Bedside Shift Report Bundle.

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Appendix B: MSU Bedside Reporting Surveillance Checklist

MSU Bedside Reporting Surveillance Checklist

	Shift	Date	1	2	3	4	5	6	7	8	9	10	Comments
Was shift report conducted at the bedside?													
Was the AHRQ standardized checklist used?													
Was the patient asked to participate?													
Was shift report conducted at the bedside?													
Was the AHRQ standardized checklist used?													
Was the patient asked to participate?													
Was shift report conducted at the bedside?													
Was the AHRQ standardized checklist used?													
Was the patient asked to participate?													
Was shift report conducted at the bedside?													
Was the AHRQ standardized checklist used?													
Was the patient asked to participate?													
Totals:													

Key:
Shift Day=D or Night=N
Answers to questions Yes= Y or No=N

Name: ______________________ Signature: ______________________ Date: ____________

Appendix C: Search Terms and Criteria

Key words & phrases	**Major authors**	**Inclusion criteria**	**Exclusion criteria**
Bedside Reporting	Jeffs, Lianne; Acott, Ashley; Simpson, Elisa; Campbell, Heather; Irwin, Terri; Lo, Joyce; Beswick, Susan; Cardoso, Roberta;	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation
Patient Nurse Communication	Blevins, Sonya; Saltore, Christopher; Hansen, lissi; Ganzini, Linda; Press, Molly; Chesnutt, Mark; Mularski, Richard	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation
Team communication	McLaughlin, Sue; Tschannen, Dana; Schoville, Rhonda; Schmidt, Patricia; Buehler, Kathryn; Borst, Sarah; Flaherty-Robb, Marna; Rabol, Louise; McPhail, Mette; Ostergaard, Doris; Andersen, Henning; Mogensen, Torben	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation
Effective Communication	The Joint Commission Knops, Karen; Lamba, Sangeeta	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation
Patient Family Centered Care	Ahmann, Elizabeth; Dokken, Debroah; Abraham, Marie; Ginn Moretz, Julie;	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation
Health Literacy	The Joint Commission	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation

Patient Hand-off	Thomas, Lily; Donohue-Porter, Patricia;	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation
Rounding	Rimmerman, Curtis; Kessler, Beth; Claude-Gutekunst, Marie; Donchez, Ashley; Dries, Rachel; Snyder, Megan; Subramony, Anupama; Schwartz, Talia; Hametz, Patricia	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation
Nurse Physician Communication	Eggertson, Laura	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation
Team Conflict	Agency for Healthcare Research and Quality	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation
Patient Involvement	Warren, Nancy; Choi, Young-Seon; Bosch, Sheila	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation
Collaboration	Bainbridge, Lesley; Nasmith, Louise; Orchard, Carole; Wood, Victoria; Hall, Carmen; Sigford, Barbara; Sayer, Nina	Research article, peer-reviewed, 2010-2013	Journal editorial, Poster presentation

Appendix D: Analysis of Literature

Summary Table of Analyzed Articles						
Citation	**Conceptual Framework/ Theory**	**Main finding**	**Research method**	**Strengths of study**	**Weaknesses**	**Level of Evidence**
(Jeffs, et al., 2013)	Nurse to nurse bedside reporting	Improves patient safety and efficient	Qualitative	43 Nurses volunteered to participate from multiple areas	From one hospital, nurses self-reported experiences	VI
(Novak & Fairchild, 2012)	Bedside reporting using S.B.A.R. Framework	Benefits of bedside reporting and standardization of hand-off communication outweigh the risks and costs	Literature Review	Identified financial implications of bedside reporting	Identified lack of research in literature, lack of randomized controlled trials and meta-analysis	V
(Rimmerman, 2013)	Physician and nurse beside rounding	Bedside rounding focuses on communication with patient and family as core contributors	Qualitative	Used multidisciplinary teams rounding at the bedside with set rounding times	Sustained support for bedside rounding	VI
(Eggertson, 2012)	Nurse-Physician Communication	Disruptive behavior inhibits effective communication.	Qualitative	8,000 staff members surveyed over 15 years. Identified ways to improved	Lack of interprofessional education	VI

				communication.		
(Thomas & Donohue-Porter, 2012)	Change, Communication, and caring	Ongoing need for leadership support	Qualitative	Pre- and post-nurse and patient satisfaction surveys	One hospital participated recommends multisite	VI
(Subramony, Schwartz, & Hametz, 2012)	Family Centered rounds	Families are knowledgeable of discharge goals and less knowledgeable of medication. English speaking know discharge plans compared to Spanish speaking.	Systematic review	Family centered rounding education provided to staff and family.	Language barriers	I
(Slatore, et al., 2012)	Communication patient centered care	Family and patient inclusion in rounds did not improve overall satisfaction	Qualitative	98% of nurses participated and comprehensive organized analysis	Communication differed between patient and day vs night shift staff. No evaluation of physician thoughts/feelings	VI
(Tschannen, et al., 2013)	Nursing Communication	Poor team communication	Cross-sectional	Nurses spent more time communicat	12 observations in	IV

		contributes to unsafe patient care	Observational	ing with team member and less time communicating with patients	three settings 144 hours and 5,167 data points	
(Maxson, Derby, Wroblesk i, & Foss, 2012)	Handoff, communica tion	Reduction in call lights during shift, patients more engaged in care decisions	Qualitati ve	Easy to score patient surveys	Sample size was one unit with 11 beds not generaliza ble to other units or facilities	VI
(Rabol, McPhail, Ostergaar d, Andersen , & Mogense n, 2012)	Team Communic ation and Patient Safety	Lack of communica tion standards and procedures with patient handoff inhibits safe information exchange, and unclear responsibili ty	Cohort	Reviewed comparative studies	Participan ts were not random but rather picked by unit leaders	IV

Appendix E: Bedside Reporting Pre-education and Training Survey

Nurses' view the aim of bedside reporting as:

1. Information for nurses

Strongly agree Agree Disagree Strongly Disagree

2. Information for the patient

Strongly agree Agree Disagree Strongly Disagree

3. Information for both nurses and patients

Strongly agree Agree Disagree Strongly Disagree

4. Other

Strongly agree Agree Disagree Strongly Disagree

Nurses' description of communication during **bedside reporting**

1. Mainly one nurse speaking, others listening

Strongly agree Agree Disagree Strongly Disagree

2. Nurses speaking mostly to themselves

Strongly agree Agree Disagree Strongly Disagree

3. Both nurses and patients taking part in conversation

Strongly agree Agree Disagree Strongly Disagree

4. Patient talks, others listen

Strongly agree Agree Disagree Strongly Disagree

5. Other

Strongly agree Agree Disagree Strongly Disagree

Patients' actively participates in the conversation during **bedside reporting**

1. Always

Strongly agree Agree Disagree Strongly Disagree

2. Often

Strongly agree Agree Disagree Strongly Disagree

3. Sometimes

Strongly agree Agree Disagree Strongly Disagree

4. Not at all

Strongly agree Agree Disagree Strongly Disagree

Bedside reporting; factors that promote or prevent patient participation.

1. Patient encouraged to ask questions

Strongly agree Agree Disagree Strongly Disagree

2. Nurses concentrate too much on patient documents

Strongly agree Agree Disagree Strongly Disagree

3. Privacy is ensured

Strongly agree Agree Disagree Strongly Disagree

4. Presence of other patients does not disturb

Strongly agree Agree Disagree Strongly Disagree

5. Relatives may participate

Strongly agree Agree Disagree Strongly Disagree

6. Too many members of staff taking part in **reporting**

Strongly agree Agree Disagree Strongly Disagree

7. Nurses are too far from patient's bed

Strongly agree Agree Disagree Strongly Disagree

8. No discussion of very personal matters

Strongly agree Agree Disagree Strongly Disagree

9. Intelligibility of speech

Strongly agree Agree Disagree Strongly Disagree

10. Nurses use medical jargon

Strongly agree Agree Disagree Strongly Disagree

11. Patient understands enough of the conversation

Strongly agree Agree Disagree Strongly Disagree

12. Patient hears the conversation well enough

Strongly agree Agree Disagree Strongly Disagree

13. Appropriate use of time

Strongly agree Agree Disagree Strongly Disagree

14. Too little time for each patient

Strongly agree Agree Disagree Strongly Disagree

(Timonen & Sihvonen, 2000).

Appendix F: Bedside Reporting: Improving the Practice Survey Letter

Date:

Dear MSU Nursing Staff:

In order to determine the satisfaction and the effectiveness of the current practice of bedside reporting, I am conducting a survey of all MSU nursing staff. Your response to this survey is crucial in providing the necessary information to formulate strengths and weaknesses of the current practice of bedside reporting.

The purpose of this survey is to determine to what extent the bedside reporting has provided benefit to you and to your patients. I would like 100% of nursing staff participation. In addition, your assessment of your bedside reporting experiences, I will provide beneficial information at the completion of the Bedside Reporting: Improving the Practice project.

On the breakroom table you will find a survey and a sealed drop box to place your survey. The survey is anonymous and no one from your leadership will read the surveys. Please feel free to include any additional comments you deem necessary or relevant to improving the program. The drop box with surveys will be picked-up one week from the date posted on the top of this letter. Your response and time is greatly appreciated. Thank you!

Very Respectfully,

Lori C. Wichman, MSN-Ed. NLM, RN, CMSRN
Walden University
DNP Student

Appendix G: Guide to Patient and Family Engagement

Guide to Patient & Family Engagement

Nurse Bedside Shift Report Training

673rd Medical Group

673D MEDICAL GROUP

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Today's session

- What is patient and family engagement?
- What are the components of bedside shift report?
- What are the benefits and challenges of bedside shift report?
- What does HIPAA say about bedside shift report?

What is patient and family engagement?

Patient and family engagement:

- Creates an environment where patients, families, clinicians, and hospital staff all work together as partners to improve the quality and safety of hospital care
- Involves patients and family members as:
  - **Members of the health care team**
  - **Advisors working with clinicians and leaders to improve policies and procedures**

Patient- and family-centered care

- Patient and family engagement is an important part of providing patient- and family-centered care
- Core concepts of patient- and family-centered care:
  - **Dignity and respect**
  - **Information sharing**
  - **Involvement**
  - **Collaboration**

Why patient and family engagement?

- Research shows patient-centered approaches can improve:
  - **Patient safety**
  - **Patient outcomes, including emotional health, functioning, and pain control**
  - **Patient experience**

Why focus on bedside shift report?

- Transitions in care have potential for medical errors
- Research shows bedside shift report can improve:
  - **Patient safety and quality**
    - Improved communication
    - Decrease in hospital-acquired complications
  - **Patient experiences of care**
  - **Time management and accountability between nurses**
    - Decrease in time needed for shift report
    - Decrease in overshift time

What is the patient and family experience at our hospital?

What is it like being a patient?

Clinicians and hospital staff	Patients and family
• Know how the hospital works and how to get things done	• Are strangers in this environment • Do not understand the system or culture • Know about their body and life situation better than hospital staff
• Know who hospital staff are and what they do	• Do not know who different staff are and what they do • May want family or friends to support them • May feel nursing staff are unavailable for multiple hours during shift change
• Are busy and under a lot of stress	• Are often in pain or uncomfortable, vulnerable, or afraid • Are worried and want to do what they can for the patient (family members) • Are aware that hospital staff are busy and may not want to bother you
• Want to provide high-quality and safe care	• Trust hospital staff to provide safe and quality care


Bedside shift report
• Critical elements
• Benefits
• Challenges
Strategy 3: Nurse Bedside Shift Report (Tool 3)
10

What is bedside shift report?

- Nursing staff conducts shift change reports at the patient's bedside
- Patient can identify a family member or close friend to participate
- Report should take about 5 minutes per patient
- Purpose:
  - **To engage the patient and family in hospital care**
  - **To share accurate and useful information between nurses, patients, and families**

Critical elements of bedside shift report

- Introduce the nursing staff, patient, and family.
- Invite the patient and family to participate
- Open medical record or electronic work station in the patient's room
- Conduct a verbal SBAR report with the patient and family, using words they can understand
- Conduct a focused assessment of the patient and a safety assessment of the room
- Review tasks that need to be done
- Identify needs and concerns of the patient and family

Benefits of bedside shift report for patients

- Acknowledges patients as partners
  - "You do get the feeling of at least being wanted. You're not just a patient in the bed."
  - "It makes you feel like you're involved."
- Builds trust in the care process
  - Shows the patient how much nurses know and do for them
  - Shows teamwork among the nursing staff, reassuring the patient that everyone knows what is going on with them

Benefits of bedside shift report for patients (continued)

- Encourages patient and family engagement
  - **Gives the patient and family an opportunity to ask questions and correct any inaccuracies in handoff**
  - **Informs the patient and family members about the patient's care throughout the stay and helps with the transition to home**

Benefits of bedside shift report for nurses

- Better information about the patient's condition
- Accountability
- Time management
- Patient safety

Video of bedside shift report

http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/video/

Video of bedside shift report (continued)

- Discussion questions:
  - **What are the overall impressions of the bedside shift report?**
  - **What went well?**
  - **What could have been done differently?**
  - **What questions or concerns do you have about bedside shift report?**

Tips for bedside shift report

- Invite patients and family at admission to participate using bedside shift report brochure (Tool 1)
- Use checklist to facilitate bedside shift report (Tool 2)
- Don't address a problem with the room or situation outgoing nurse in front of the patient
- Thank the nurse going off duty if everything is in good shape

Potential challenges

- Unknown visitors or family in the room
- New diagnosis or information patient is not yet aware of (e.g., waiting for doctor to discuss)
- Patient is asleep
- Patient is noncompliant and you need to share information with oncoming nurse
- Patient or family has a complex question or needs a lengthy clarification
- Semi-private rooms and HIPAA concerns

HIPAA and Bedside Shift Report

Adapted from Emory University Bedside Shift Report Bundle Training

Addressing HIPAA concerns

- Health information can be disclosed for:
  - **Treatment**
  - **Health care operations**
  - **Payment**
- HIPAA acknowledges incidental disclosures may occur
- Not a HIPAA violation as long as
  - **Take reasonable safeguards to protect privacy**
  - **Disclose only or use the minimum necessary information**

Addressing HIPAA concerns (continued)

- Is a covered entity required to prevent any incidental use or disclosure of protected health information?
- Answer: No. The HIPAA Privacy Rule does not require that all risk of incidental use or disclosure be eliminated to satisfy its standards. Rather, the rule requires only that covered entities implement reasonable safeguards to limit incidental uses or disclosures. See 45 CFR 164.530(c)(2).

Addressing HIPAA concerns (continued 2)

- Can physicians and nurses engage in confidential conversations with other providers or with patients, even if there is a possibility that they could be overheard?
- Answer: Yes. HIPAA does not prohibit providers from talking to each other and to their patients. Providers' primary consideration is the appropriate treatment of their patients.

Addressing HIPAA concerns (continued 3)

- Oral communications often must occur freely and quickly. Covered entities are free to engage in communications as required for quick, effective, and high-quality health care. For example:
  - **Coordinate services at nursing stations**
  - **Discuss a patient's condition or treatment regimen in the patient's semiprivate room**
  - **Discuss a patient's condition during training rounds in an academic or training institution**

Appendix H: Post-education and Training Survey

Nurses' view the aim of bedside reporting as:

1. Information for nurses

Strongly agree Agree Disagree Strongly Disagree

2. Information for the patient

Strongly agree Agree Disagree Strongly Disagree

3. Information for both nurses and patients

Strongly agree Agree Disagree Strongly Disagree

4. Other

Strongly agree Agree Disagree Strongly Disagree

Nurses' description of communication during **bedside reporting**

1. Mainly one nurse speaking, others listening

Strongly agree Agree Disagree Strongly Disagree

2. Nurses speaking mostly to themselves

Strongly agree Agree Disagree Strongly Disagree

3. Both nurses and patients taking part in conversation

Strongly agree Agree Disagree Strongly Disagree

4. Patient talks, others listen

Strongly agree Agree Disagree Strongly Disagree

5. Other

Strongly agree Agree Disagree Strongly Disagree

Patients' actively participates in the conversation during **bedside reporting**

1. Always

Strongly agree Agree Disagree Strongly Disagree

2. Often

Strongly agree Agree Disagree Strongly Disagree

3. Sometimes

Strongly agree Agree Disagree Strongly Disagree

4. Not at all

Strongly agree Agree Disagree Strongly Disagree

Bedside reporting; factors that promote or prevent patient participation Patient-centeredness

1. Patient encouraged to ask questions

Strongly agree Agree Disagree Strongly Disagree

2. Nurses concentrate too much on patient documents

Strongly agree Agree Disagree Strongly Disagree

3. Privacy is ensured

Strongly agree Agree Disagree Strongly Disagree

4. Presence of other patients does not disturb

Strongly agree Agree Disagree Strongly Disagree

5. Relatives may participate

Strongly agree Agree Disagree Strongly Disagree

6. Too many members of staff taking part in **reporting**

Strongly agree Agree Disagree Strongly Disagree

7. Nurses are too far from patient's bed

Strongly agree Agree Disagree Strongly Disagree

8. No discussion of very personal matters

Strongly agree Agree Disagree Strongly Disagree

9. Intelligibility of speech

Strongly agree Agree Disagree Strongly Disagree

10. Nurses use medical jargon

Strongly agree Agree Disagree Strongly Disagree

11. Patient understands enough of the conversation

Strongly agree Agree Disagree Strongly Disagree

12. Patient hears the conversation well enough

Strongly agree Agree Disagree Strongly Disagree

13. Appropriate use of time

Strongly agree Agree Disagree Strongly Disagree

14. Too little time for each patient

Strongly agree Agree Disagree Strongly Disagree

(Timonen & Sihvonen, 2000).

Appendix I: License Terms and Conditions

RightsLink Printable License

JOHN WILEY AND SONS LICENSE TERMS AND CONDITIONS

Nov 15, 2016

This Agreement between Lori C Wichman ("You") and John Wiley and Sons ("John Wiley and Sons") consists of your license details and the terms and conditions provided by John Wiley and Sons and Copyright Clearance Center.

License Number	3990440393860
License date	Nov 15, 2016
Licensed Content Publisher	John Wiley and Sons
Licensed Content Publication	Journal of Clinical Nursing
Licensed Content Title	Patient participation in bedside reporting on surgical wards
Licensed Content Author	Leena Timonen,Marja Sihvonen
Licensed Content Date	Dec 24, 2001
Licensed Content Pages	7
Type of use	Dissertation/Thesis
Requestor type	Author of this Wiley article
Format	Print and electronic
Portion	Full article
Will you be translating?	No
Title of your thesis / dissertation	Bedside Reporting: Improving Practice
Expected completion date	Aug 2017
Expected size (number of pages)	100
Requestor Location	Lori C Wichman 10600 Main Tree Drive ANCHORAGE, AK 99507 United States Attn: Lori C Wichman
Publisher Tax ID	EU826007151
Billing Type	Invoice
Billing Address	Lori C Wichman 10600 Main Tree Drive ANCHORAGE, AK 99507 United States Attn: Lori C Wichman
Total	0.00 USD
Terms and Conditions	

TERMS AND CONDITIONS

This copyrighted material is owned by or exclusively licensed to John Wiley & Sons, Inc. or one of its group companies (each a"Wiley Company") or handled on behalf of a society with

Appendix J: PDSA Worksheet for Testing Change

Institute for Healthcare Improvement

PDSA Worksheet for Testing Change

Aim:

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds

Do Describe what actually happened when you ran the test

Study Describe the measured results and how they compared to the predictions

Act Describe what modifications to the plan will be made for the next cycle from what you learned