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Improving Patient Care Outcomes by Standardizing Change of Shift Report

Marie E. Gutierrez, MSN, BSN, RN

University of San Francisco

Improving Patient Care Outcomes by Standardizing Change of Shift Report

The change of shift is one of the most crucial times during a nurse's day, it is a time where vital patient information is passed off from one nurse to the next. There is evidence that the root cause of many sentinel events and poor patient outcomes in related to communication breakdown during the change of shift report process. The patient population includes a diverse geriatric adult population with the average age being around sixty five years old. This unit consists of twenty eight beds. There are approximately four to five nurses on the floor caring for the patients along with a charge nurse and a break relief nurse.

Clinical Leadership Theme

The clinical leadership competencies that aligns best for my Clinical Nurse Leader (CNL) project focuses on communication and coordinator of care. The goal is to improve nurse to nurse communication during change of shift report by implementing a standardized change of shift report sheet. I aim to improve the change of shift report process by focusing on the improvement of communication. The change of shift report process begins with the off-going nurse giving report and oncoming nurse receiving report. The process ends with oncoming nurse assuming care of the patient and beginning the shift. Utilizing the resources and assistance available to me, I will be collecting data on improvements that can be made to improve the change of shift process.

Statement of the Problem

Patient care outcomes and nurse to nurse communication can suffer without the standardization of the change of shift report process. Change of shift report is an elaborate communication process that involves the transition of care between nurses as well as other clinicians. During the change of shift there is a complex exchange of vital patient information

regarding diagnosis, plan of care, health history and other related social issues. Unfortunately there is still a lapse in information exchange during change of shift report due to a lack of standardization. Developing a standardized change of shift report sheet will hopefully improve patient care outcomes, reduce overtime, and improve patient satisfaction.

Project Overview

This project was conducted on the medical surgical telemetry unit in a hospital located in Daly City, CA. The patient population includes a diverse geriatric adult population with the average age being around sixty five years old. This unit consists of twenty eight beds. The majority of the conditions treated on this unit consists of general surgery, heart conditions, sepsis, chronic conditions such as chronic obstructive pulmonary disorder and diabetes, urinary tract infections, etc. There is a high turnover of patients with the average length of stay being three days. Most days on the unit the census is around twenty to twenty four patients, and the nursing staff consists of a charge nurse, break relief nurse, and four to five nurses on the floor caring for patients. Each nurse typically gets up to four patients unless certain patients are a higher acuity the nurse can take three patients. There are a total of forty registered nurses on the unit as well as twelve support staff including nursing assistants and unit secretaries.

This project aims to improve patient care outcomes by improving communication between nurses and other clinicians during the change of shift process. During change of shift report there are lapses in communication that can lead to medication error, repeat tests and procedures, falls, and a multitude of other issues. The Agency for Healthcare Research and Quality (2013) reported that approximately 70% of adverse patient events are related to communication failures between healthcare providers. According to Vines, Dupler, Van Son, &

Guido (2014) the transfer of information should be complete, accurate, and consistent and is imperative to providing safe patient care.

The aim for my project is to improve patient care outcomes by improving communication between nurses. In addition, developing a more standardized way of giving and receiving change of shift report through the use of a change of shift report sheet. The goals of my project is to improve patient safety by 25% within ninety days of implementation and improve patient satisfaction by 25%.

Rationale

Identifying the factors leading to the lapses in communication and worsening patient care outcomes required a root cause analysis and microsystem assessment. A series of surveys given to the nurses and observations conducted during the change of shift report process were conducted. The data from the microsystem assessment, change of shift observations and surveys were collected to perform the root cause analysis involving issues with communication during the change of shift report process. According to the data compiled, one of the most prevalent problems were lapses in communication and missing information as well as not performing hand off in the patient's rooms. Nurses were inconsistent with the information that would be handed off and report was given at the nurses station. The patient as well as the patient's family were unable to participate and hear what the plan of care involved. There were other outlying problems including call lights going off in the middle of report with no nursing assistants around to answer them leading the nurses to interrupt their report to see what the patient needed. A root cause analysis (Appendix A) and strengths weakness opportunities and threats analysis (SWOT) (Appendix B) was performed to further investigate potential factors that influence current practice.

A cost analysis was conducted to identify the costs for printing out a report sheet. The cost for printing a report sheet is fairly inexpensive (Appendix D). The cost for printer ink, specific to the unit, is estimated at $100.00. A case of printer paper which includes 5,000 sheets is estimated at $25.00.The introduction and implementation of the report sheet can be brought up during the huddle at the beginning of every shift as well as an example posted in the breakroom for nurses to look over during their breaks. In doing so, this allows non-productive hours to be kept to a minimum. Overall, implementing this project would improve outcomes on this unit and hopefully hospital wide in the long run. It will assist with improving patient care outcomes and strengthening nursing communication skills.

By implementing this project, I am hoping to develop a sense of accountability by encouraging nurses to improve their communication skills and develop consistent behavior of performing a standardized report at the patient's bedside. Emphasizing the importance of patient satisfaction will allow the nurses to address what is important to the patient during their stay here in the hospital and keep patient satisfaction scores up.

Methodology

Whenever change is going to be implemented the first step is to identify a need for change and what impact it will have. I was able to assess the need for the standardization of change of shift report due to an increase in poor patient outcomes and increased overtime. Lewin's Change Theory acted as guide to implement my clinical project. The unfreezing stage was important during my microsystem assessment to discover why the change of shift report process needed to improve. The moving stage involved conducting a survey to see where change can be made. It was important to conduct a survey with the nurses who will be using the report sheet (Appendix E). This pre-implementation survey offered Likert style questions to provide

concrete data results. The refreezing stage began with the utilization of a standardized report sheet. The introduction of the report sheet was discussed during the huddle at the beginning of every shift as well as an example posted in the breakroom for nurses to look over during their breaks. The survey was handed out to nurses at the beginning of the shifts and collected when the nurses completed them. The next step was to create the shift report tool based on the survey responses and the help of my preceptor (Appendix F).

Data Source and Literature Review

A literature review was conducted on the effects of ineffective change of shift handoff and supported the concept that lack of standardization can lead to poor patient outcomes. While conducting research several databases were utilized including: CINAHL, PubMed, and Google Scholar. The PICO statement utilized was "For patients in the acute care setting does a standardized uniform change of shift, compared to a nurse's own style of giving report, improve patient care outcomes and patient satisfaction?". The articles chosen were limited to being published only from 2012-2017.

The Joint Commission found the root cause of 70% of hospital-related sentinel events involved communications, with 50% of those events occurring during patient care handoffs. Riesenberg, Leitzsch, and Cunningham (2012) conducted a review of literature on nursing handoffs and how little is known about what constitutes best practice. They found that in an Australian study of more than 14,000 admissions, 17% were associated with an adverse event; in 11% of those events, communication problems were found to be a contributing factor (Riesenberg, Leitzsch, & Cunningham, 2012). Foster-Hunt, Parush, Ellis, Thomas, and Rashotte (2015) conducted an observational study in the pediatric intensive care unit on nursing handoff. The data collected showed that nurses employed common categorization strategies when

transferring information during change of shift handoffs but not identical in detail or sequence of information and that level of experience also played a factor in the degree of organization. This lack of organization and streamlined communication can lead to poor patient outcomes or medication errors.

In article published by Duckworth (2016) he discusses five recommendations so that responsibility for the patient is clear, critical care is not interrupted, an effective mental model is shared, priority next steps are facilitated, transferred information is complete and errors are minimized. Duckworth came up with the pneumonic *EEESS* which stands for eye contact, environment, ensure the ABCs, structured report, and supply documentation. This type of standardization is vital to guaranteeing patient safety. Dubosh, Carney, Fisher and Tibbles (2014) discuss how communication breakdowns among clinicians are a commonly recognized source of error and are associated with 61% of sentinel events. The authors discuss their implementation of a standardized emergency room checklist that showed an 20% improvement of the oncoming clinician being all aware of the plan for the patient.

Jukkala, James, Autrey, Azuero, and Miltner (2012) utilized the clinical microsystem framework to engage staff in their study to introduce a standardized communication tool in the medical intensive care unit. Findings from the pilot study indicated that communication among nurses during change of shift report improved significantly following implementation of the standardized communication tool. A clinical nurse at Sloan Kettering, Taylor (2015) introduced a standardized handoff report sheet to improve communication, patient safety and satisfaction. She also went on to discuss the implementation of walking rounds in which the off going nurse is able to make introductions and address any clinical concerns or questions with the patient and

family. This patient participation is expected to improve patient satisfaction and improve patient outcomes.

Timeline

This project began in early June 2017 and will conclude by the end of August 2017. Refer to Appendix C for process map and Appendix G for Timeline. The project start date was delayed due to multiple factors. There was a delay in initially finding preceptor and clinical placement. Scheduling conflicts added to the delay in project implementation.

In early June my preceptor and I discussed the need to improve change of shift hand off report and spoke with the nurse manager of the unit as well as the nurse educator. Once approved by all parties I spoke with several nurses on the unit and handed out a survey that asked where improvements can be made with the change of shift process. Throughout the rest of June several shifts were spent observing change of shift report and the many styles the nurses used. The development of the change of shift report sheet was a collaboration between my preceptor and myself. The next steps included introducing the report sheet to the nurses during the huddle as well as leaving a copy in the break room to allow time for familiarization. By the end of June the nurses were starting to implement the use of the report sheets.

Expected Results

After the implementation and completion of this project I expect for patient outcomes to improve, a decrease in overtime, an increase in patient satisfaction, and improvement in communication skills amongst all clinicians. I expect for there to be some areas of resistance from the nurses, not wanting to change their ways to adapt to a whole new way to give report but I hope with the evidence that I provide for them and demonstrate the importance of

accountability each nurse will feel more inclined to adapt to a standardized change of shift report.

Nursing Relevance

Patient safety is and will always be the number one priority in the healthcare system. Unfortunately patient satisfaction seems to suffer due lack of participation in the change of shift report process. During report nurses are passing of vital pieces of patient information but unfortunately there are knowledge gaps in what needs to be done to improve communication skills. Lack of consistency and streamline communication can put the patient at risk for adverse events or even death.

Summary Report

The objective of the CNL internship project is to improve nurse to nurse communication during the change of shift handoff report with the implementation of a standardized change of shift report sheet and best practice tips for the nurses to follow. The aim of my project improve patient safety by 25% within ninety days of implementation and overtime hours will decrease by 15% within ninety days of implementation. A follow up survey (Appendix I) will be distributed after the 90 day mark of implementation to follow up on the best practices tip sheet (Appendix H).

This project was conducted on the medical surgical telemetry unit in a hospital located in Daly City, CA. The patient population includes a diverse geriatric adult population with the average age being around sixty five years old. This unit consists of twenty eight beds. A microsystem assessment as well as direct observational studies were conducted that showed the need for the improvement of nurse to nurse communication during change of shift report. A pre-implementation survey was utilized to evaluate and better understand the needs and concerns of

the nurses on the unit. Results for the pre-implementation survey are seen in Appendix J. This CNL project started in early June, with implementation of the standardized report sheet in late June. The use of the standardized report sheet as well as a best practice tips handout aided in the implementation of this project. Updates and further education was provided during huddles at the beginning of each shift to emphasize the importance of this project.

The original aim for this project was to improve patient care outcomes by improving communication between nurses. The goals of my project is to improve patient safety by 25% within ninety days of implementation and improve patient satisfaction scores. Although it has not been ninety days since the initial implementation of the project we have already seen a 10% increase in patient safety outcomes. With the implementation of the standardized report sheets there are less chances for information to be missed during the change of shift report process.

Another aspect of the CNL project was improving patient satisfaction scores. Prior to the implementation of the project patients and their families had voiced that they did not feel included in the plan of care and sometimes had no idea what to expect for the day. After direct observations and introduction of the best practice tip sheet, nurses were performing change of shift at the bedside including the patients in the report process. Many patients and their families voiced how much more confident they felt in the care they were receiving when they had the opportunity to listen and contribute to the nurse to nurse report process.

The sustainability of this project will be well supported the collective nursing staff; nurse manager, nursing educators, and nursing staff. This project will directly coincide with their new update they will be adding to their current electronic health record. During the course of the semester I had the opportunity to speak with a member of the nursing informatics team. This new tool that will be added to their EHR system is a change of shift checklist that both the off

going and oncoming nurse will have to cosign as if it were a high risk medication. The use of this new tool will strengthen this project by providing nurses with the most up to date patient information while they are giving report. With all these tools my hope is for this implementation to become much more than a project but a daily practice. The medical center's core values are respect, caring, integrity, passion, and stewardship. This project aligns with these values especially integrity, care, and stewardship. The value of integrity in this project aims to allow nurses to be transparent while giving report by including patients and their family. The value of caring aligns with providing the best possible high quality care by improving nurse to nurse communication during the change of shift report process. The value of stewardship is defined as being creative in our approach to challenges and opportunities and being accountable for the results we want to achieve as a charitable organization. The project aims to take on the need to improve nursing communication and help the nurses to feel more accountable and take ownership in this quality improvement process.

Overall the results from this project demonstrated that implementing a standardized report process and education on best practice tips to follow during report positively impacted nursing care. Identifying patient needs as well as nursing needs through pre-implementation surveys and direct observation enabled for a plan to improve the change of shift process. Going forward the hope for this project and with the success it reached on this unit that it will be adopted throughout the hospital to ensure that patient centered care and patient safety always come first.

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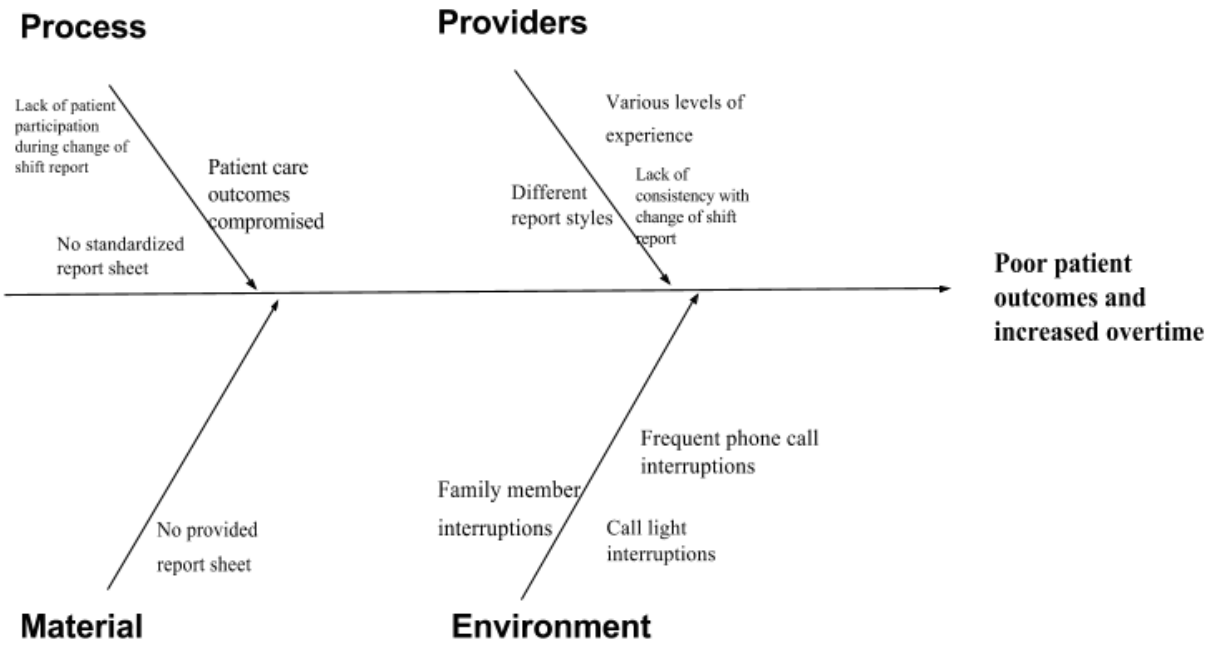
Appendix A

Root Cause Analysis Fishbone



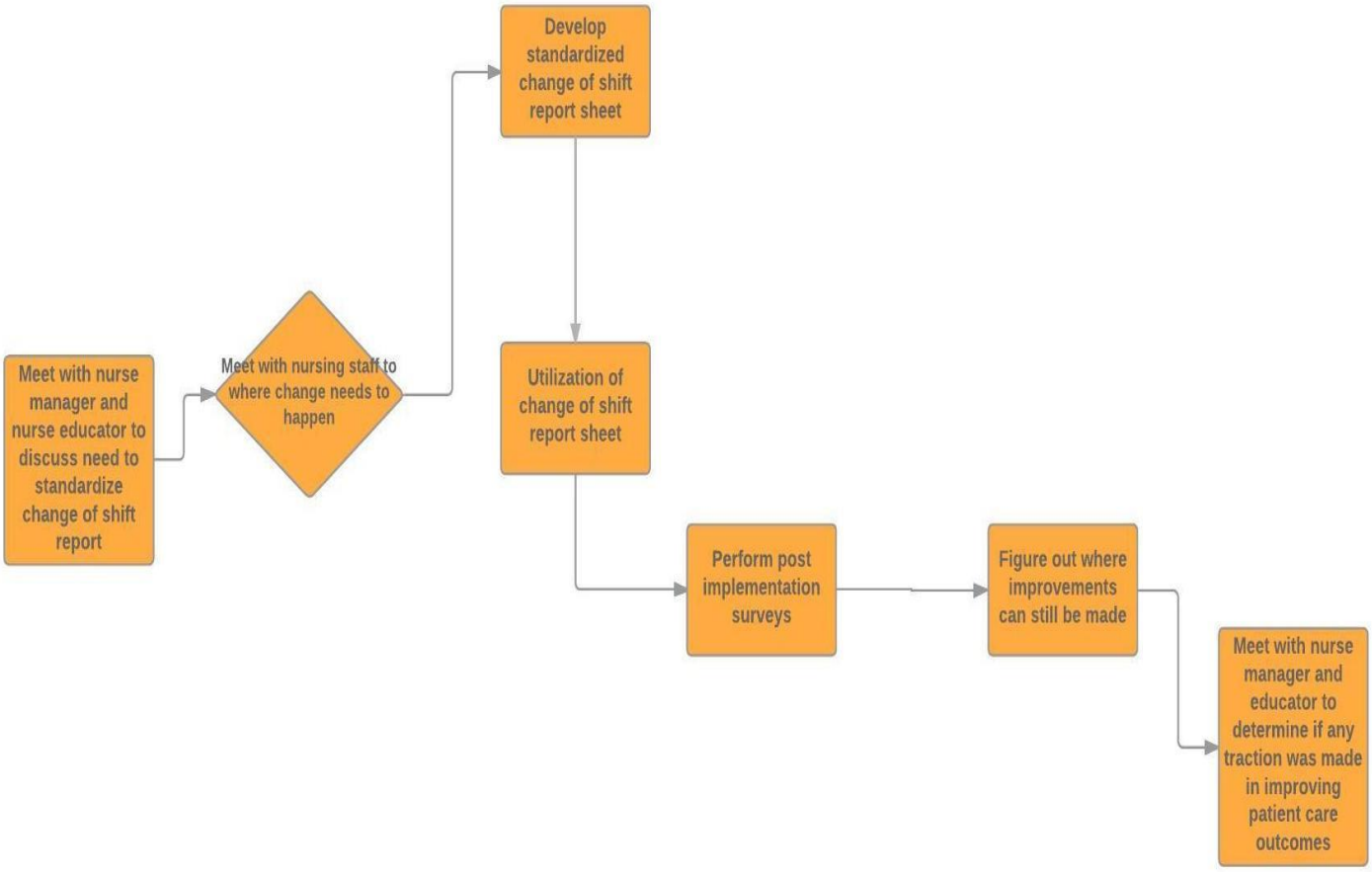
Appendix B

SWOT Analysis

Strengths	Weakness
● Staff willing to change ● Dedicated leadership ● Well educated staff	● Poor communication skills ● Decreased patient satisfaction ● Lack of standardized report process
Opportunities	**Threats**
● Improved patient care outcomes ● Improved communication process ● Reduce overtime ● Involvement of patient/families during report	● Staff pushback ● Lack of compliance with new report sheet

Appendix C

Process Map



Appendix D

Cost Analysis

Items	Initial Cost	Yearly Cost
Paper	$25.00	$100.00
Ink	$100.00	$600.00
Total	$125.00	$700.00

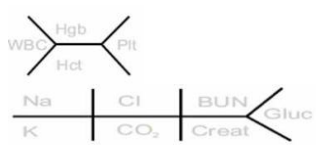
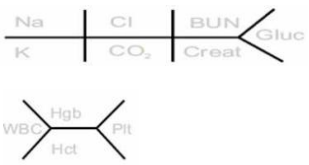
Appendix E

Pre-Implementation Change of Shift Survey

1. Does change of shift report take longer than 15-20 minutes?
    a. Always
    b. Sometimes
    c. Neutral
    d. Rarely
    e. Never
2. Does change of shift report take longer than 25-30 minutes?
    a. Always
    b. Sometimes
    c. Neutral
    d. Rarely
    e. Never
3. How often does change of shift report cause you overtime?
    a. Always
    b. Sometimes
    c. Neutral
    d. Rarely
    e. Never
4. Do you feel that the change of shift process can be improved?
    a. Yes
    b. No
5. Would a improved standardized report sheet be beneficial to you?
    a. Yes
    b. No
6. What is the most missed piece of information during report?
    a. Next steps
    b. Familial concerns
    c. Social concerns
    d. Medications
    e. Tests/ Labs
    f. Diet
    g. Other:_____
7. Do you perform report at the bedside with the patient/family involved?
    a. Always
    b. Sometimes
    c. Neutral
    d. Rarely
    e. Never

Appendix F

Report Sheet

Patient: Room #: Age: Sex: MD:	DX: PMH:	Patient: Room #: Age: Sex: MD:	DX: PMH:
NEURO/MUSC	AxO Confused? Activity: Restraints:	NEURO/MUSC	AxO Confused? Activity: Restraints:
CVS	SB SR SF/SFL Edema: SCDS	CVS	SB SR SF/SFL Edema: SCDS
PULMONARY	RA O2 Neb TX Sat%	PULMONARY	RA O2 Neb TX Sat%
GI/DIET	Last BM Diet: Fluid Restriction: Feeder:	GI/DIET	Last BM Diet: Fluid Restriction: Feeder:
GU	Foley: Last Void:	GU	Foley: Last Void:
SKIN/WOUND	Wound Care TX Pacer Wires	SKIN/WOUND	Wound Care TX Pacer Wires
PAIN	Level: Last Pain Med Given:	PAIN	Level: Last Pain Med Given:
IV	G: Fluids:_____@ _____ml/hr Date Inserted:	IV	G: Fluids:_____@ _____ml/hr Date Inserted:
BLOOD GLUCOSE	AC HS	BLOOD GLUCOSE	AC HS
PROCEDURES	CT/MRI US XRAY	PROCEDURES	CT/MRI US XRAY
LABS		LABS	
SOCIAL CONCERNS		SOCIAL CONCERNS	

Appendix G

Timeline

Events	May	June	July	August	September
Project Approval					
Microsystem Analysis and Observations					
Literature Research					
Pre-implementation Survey and Discussion with staff					
Survey Results					
Create Report Sheet					
Introduction of report sheet to staff					
Ongoing assessment					
Post implementation Survey					

Appendix H

Best Practice Tips Handout

Best Practice Tips for Improving Change of Shift Communication

By: Marie Gutierrez MSN BSN RN
University of San Francisco
Master of Science in Nursing-CNL Project

The Joint commission has identified communication as the primary cause for preventable medical errors with handoffs accounting for 80% of these instances.

Communicate Clearly
- Effective communication is a dynamic process where are asked and concerns are voiced

Focus and Avoid Distraction
- Take the time to let patients know that you are about to go into report and ask if there is anything you can do for them so they will not be distracting you with call lights

Make Drug Information a Priority
- Make sure to touch on the medications the patient is taking especially any new medications that may cause adverse side effects

Report at the Bedside
- Practice giving report at the patient's bedside and involve the patient or patient's family if appropriate, this practice will allow for open communication between the nurses and their patients

Utilize the Electronic Healthcare Record
- Have the patient's chart open while giving report so you and the oncoming nurse are able to look over new orders, lab results or any other questionable issues in the chart

Utilize Standardized Report Sheets
- Go through each section with the oncoming nurses so there is time allotted for any clarifications

Utilize the SBAR
- *Situation*—Identify the general problem and any focused priority.
- *Background*—Focused history of present issue/injury, prior care and relevant history.
- *Assessment*—Key findings and vital signs, including the patient's current state.
- *Recommendation*—Identify the patient's immediate needs, if any.

Make Sure to Review Next Steps and Plan of Care
- Go over the plan of care with the oncoming nurse to discuss what the next steps are for the patient so the oncoming nurse will have a better understanding of what to expect for their shift
- Discuss the need for telemetry and if the patient can be taken off monitoring

Discuss Any Need for Interdisciplinary Involvement
- Discuss options if a case manager or social worker needs to become more involved with the patient's case to improve discharge planning

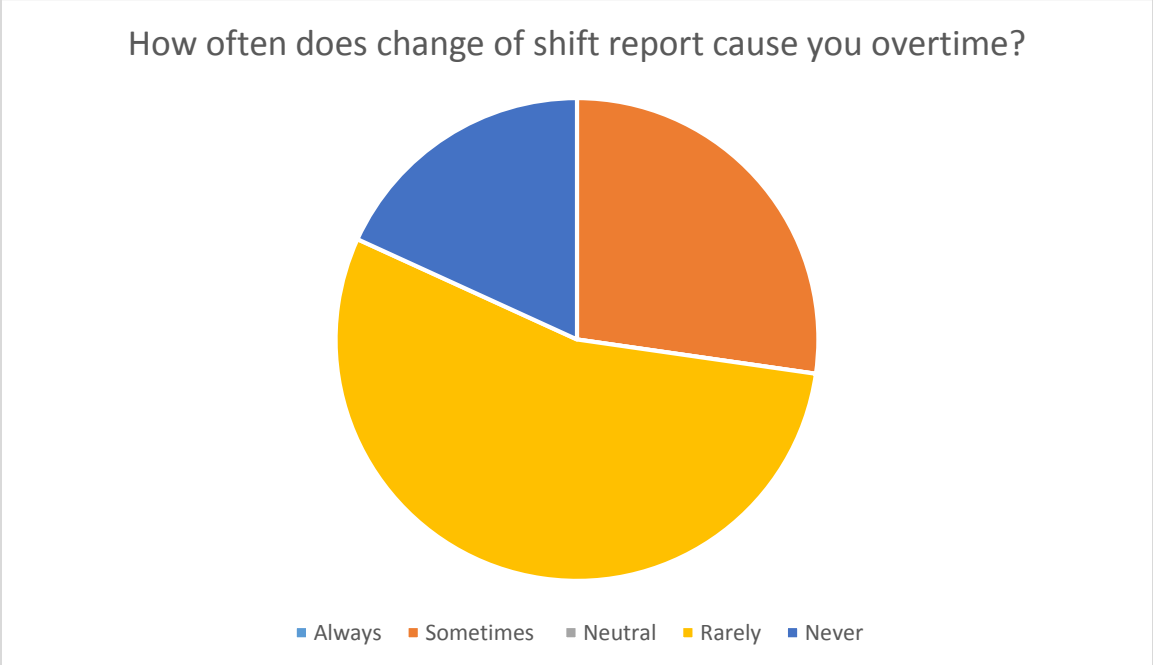
Appendix I

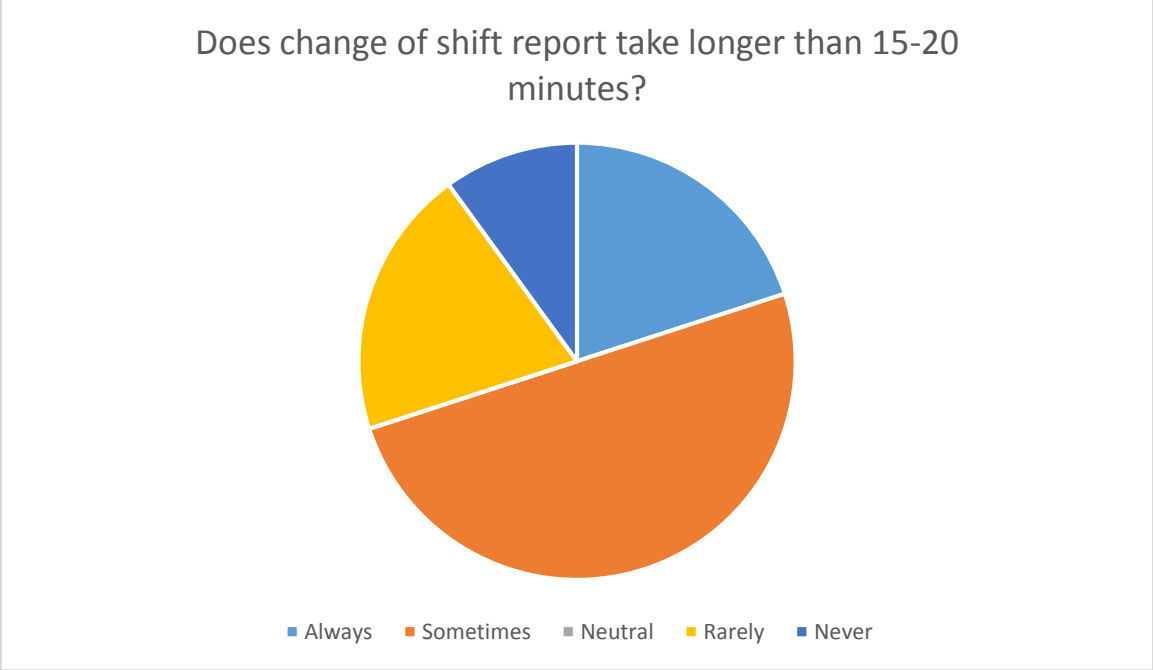
Post Implementation Change of Shift Survey

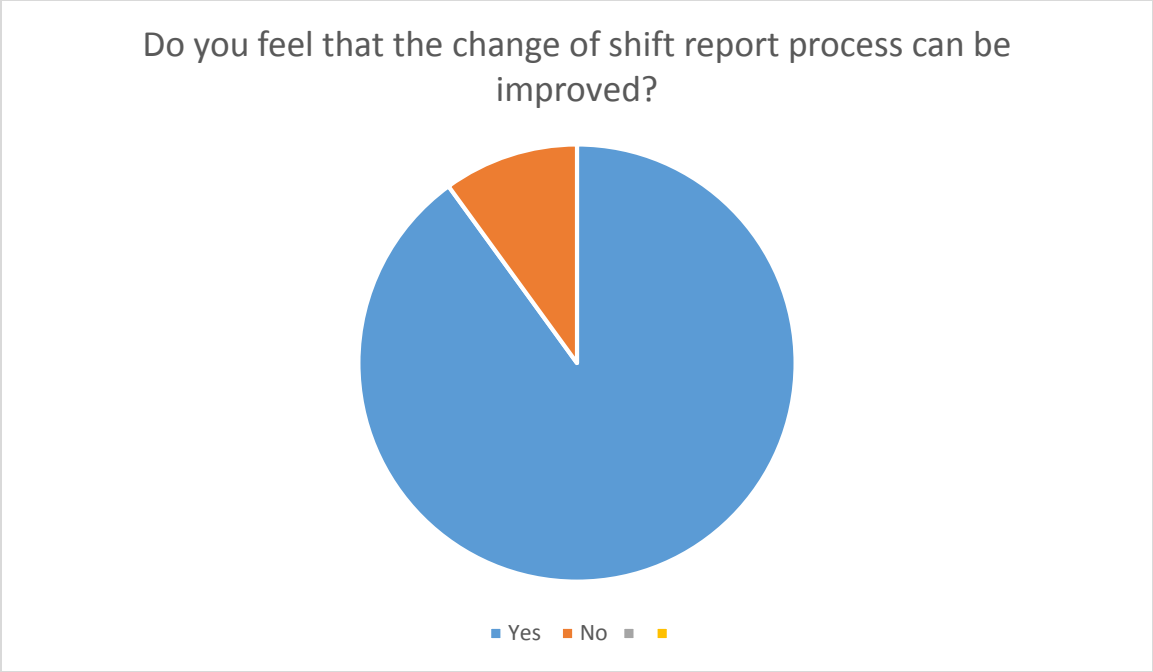
1. Does change of shift report take longer than 15-20 minutes?
    a. Always
    b. Sometimes
    c. Neutral
    d. Rarely
    e. Never
2.. How often does change of shift report cause you overtime?
    a. Always
    b. Sometimes
    c. Neutral
    d. Rarely
    e. Never
4. Do you feel that the change of shift process has been improved?
    a. Yes
    b. No
5. Does the standardized report sheet help make change of shift report more efficient?
    a. Yes
    b. No
6. What is still the most missed piece of information during report?
    a. Next steps
    b. Familial concerns
    c. Social concerns
    d. Medications
    e. Tests/ Labs
    f. Diet
    g. Other:_____
7. Are you making a conscious effort to perform report at the bedside with the patient/family involved?
    a. Always
    b. Sometimes
    c. Neutral
    d. Rarely
    e. Never

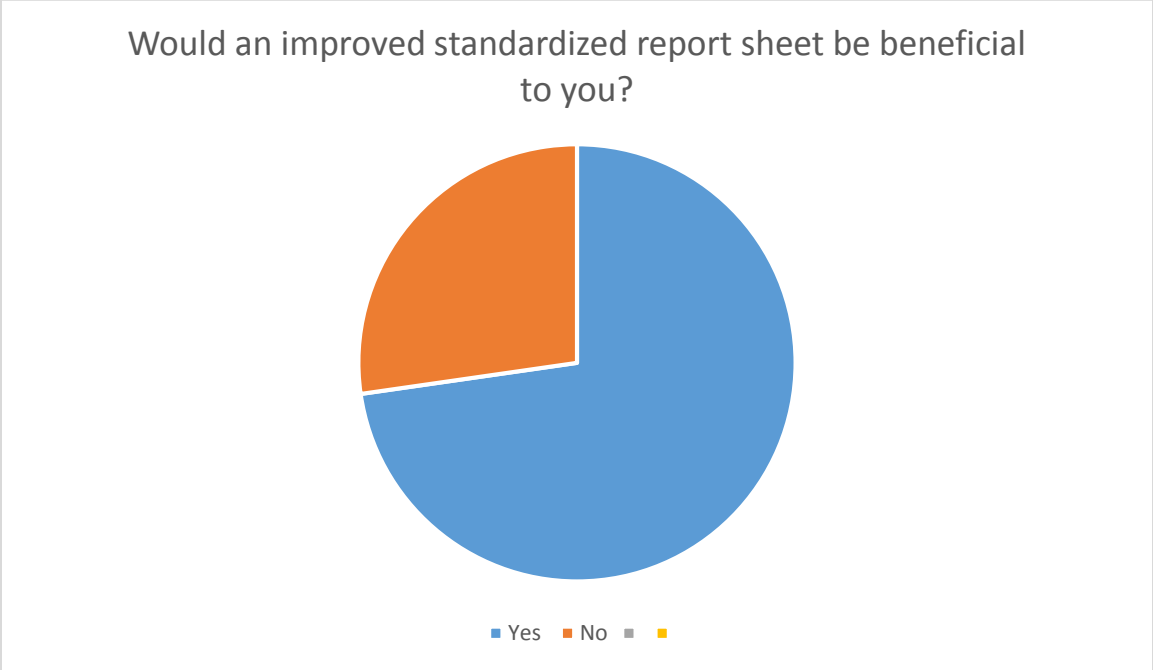
Appendix J

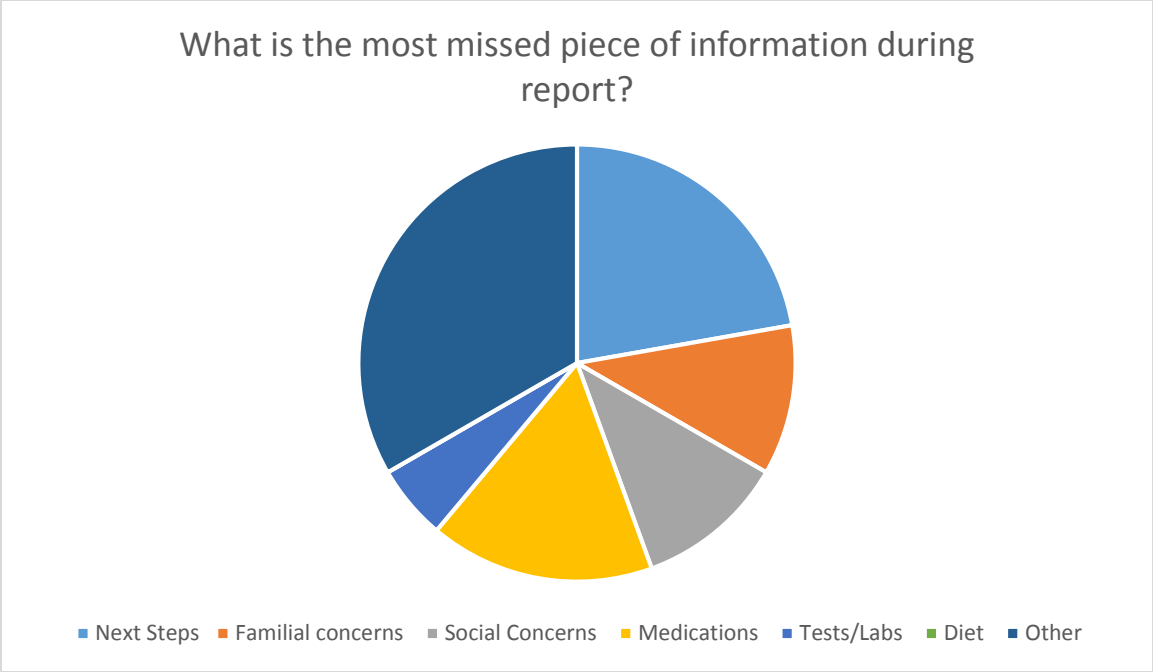
Pre-Implementation Survey Results

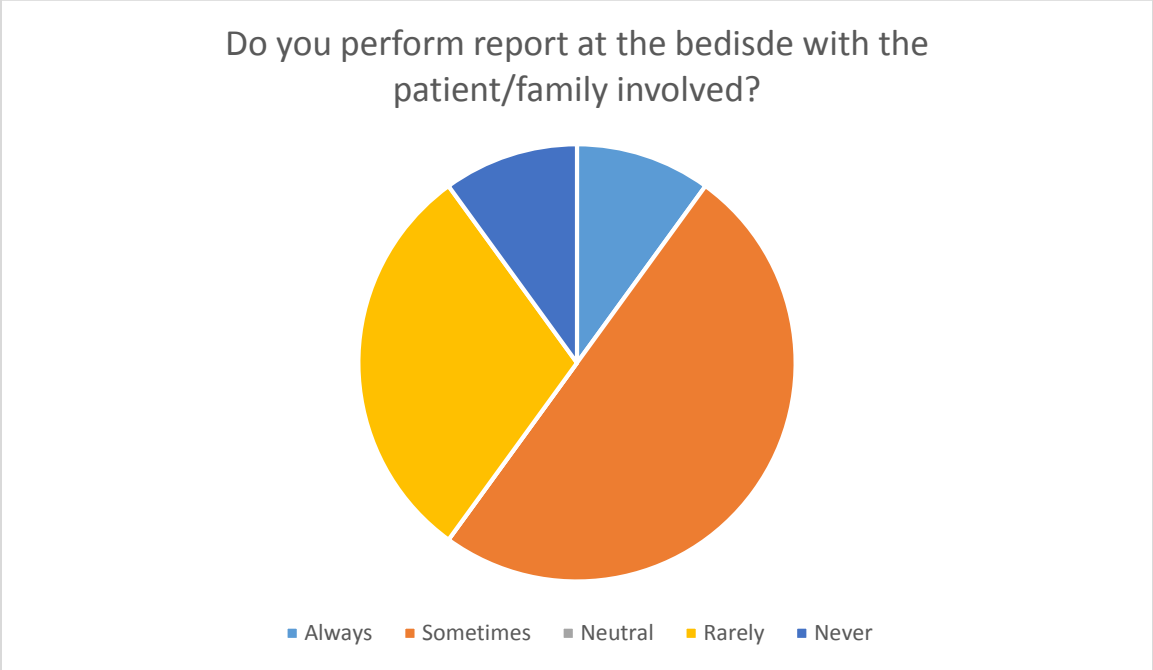





Do you feel that the change of shift report process can be improved?
Yes
No


Would an improved standardized report sheet be beneficial to you?
Yes
No


What is the most missed piece of information during report?
Next Steps
Familial concerns
Social Concerns
Medications
Tests/Labs
Diet
Other


Do you perform report at the bedisde with the patient/family involved?
Always
Sometimes
Neutral
Rarely
Never