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Communication

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Clinical Leadership Theme

The aim of this Clinical Nurse Leader (CNL) project is to improve the communication and collaboration among the nurses at Rosewood Care Center's sub-acute unit. The process of bedside shift report (BSR) is an evidence-based practice that will be part of the unit's nursing quality improvement initiative. The goal is to develop a change in nursing practice that will ensure the delivery of safe, quality, and effective patient care. The project focuses on the CNL's core curriculum of Quality Improvement and Safety under the role of an outcomes manager, who incorporates data, knowledge, and information to assess and promote positive patient outcomes (AACN, 2013).

The CNL functions within the microsystem as an agent of change, involved in the quality improvement processes, which are intended to improve the delivery of patient care and outcomes. As defined by the American Association of Colleges of Nursing (2013), the CNL "assumes accountability for patient care outcomes through the assimilation and application of evidence-based information to design, implement, and evaluate patient care processes and models of care delivery" (p. 4).

Statement of the Problem

The sub-acute unit at Rosewood Care Center is a 27-bed unit that specializes in traumatic brain injury, post cardiac arrest, and acute and chronic respiratory care. The staff is composed of the registered nurses (RNs), vocational nurses (LVNs), patient care assistants, unit manager, nursing supervisor, and registered respiratory therapists (RRTs). At least 40% of the nurses are newly licensed and newly hired, as the unit reported a high nursing turnover during the last 8 months. In order for the patients to be admitted to the unit, they must meet the criteria for

admission. The majority of the patients in the sub-acute unit (85%) are in a persistent vegetative state, 100% of the patients have a tracheostomy in place, 60% are on a mechanical ventilator for respiratory support, and most of them (95%) receive their medications and nutrition via a gastrostomy tube. The unit is considered the ICU of the institution, as the majority of the patients require close monitoring and a 24-hour extensive assist nursing care.

Effective communication between the nurses during the change-of-shift is vital in order to ensure that safe, quality, and effective care is delivered. Yet, communication and collaboration were cited as the leading causes of patient harm across healthcare facilities (King & Gerard, 2016). The Agency for Healthcare Research and Quality (2013) reported that at least 70 % of patient adverse events are attributed to communication failures between caregivers. Most of the nurse-to-nurse communications occur during the shift handoff report, between the outgoing and incoming nurses. This process occurs when the outgoing nurse transfers critical information pertinent to the patient including lab results, new medication orders, new recommendations from other disciplines, and any changes in patient's condition. It is imperative that at this moment the transfer of information should be complete, accurate, and consistent (Vines, Dupler, Van Son, & Guido, 2014). Standardizing the process of shift handoffs through bedside reporting can help improve the effectiveness of nurse-to-nurse communication, which is essential in ensuring patient safety.

The change-of-shift reports or shift handoffs in the sub-acute unit occur mostly at the nurse's station or by the medication cart, away from the patient. Oftentimes, shift handoffs do not start on time, as many of these nurses gather at the nurse's station to discuss issues not pertinent to their patients. It is very common for these nurses to socialize and gossip prior to conducting the shift handoffs. As a result, the process of exchanging patient information is often

rushed and incomplete, making it difficult for the incoming nurses to prioritize and provide

patient care. In addition, the outgoing nurses would sometimes wait for the incoming nurses as

they finish socializing, which results in outgoing nurses leaving late. Based on my observations,

the shift handoffs often lack accuracy and consistency, which is particularly frustrating to the

newly hired nurses. Even if the patient is newly admitted to the unit and the nurse is new or has

been off for two days, the outgoing nurse would simply say "room 11A is ok, no change".

Furthermore, conflicts occur between the nurses as a result of the lack of communication

during the shift handoffs. New physician's orders such as a change in medication dose, tube

feeding formula and rate change, and critical lab results are sometimes not communicated

properly between the nurses. In addition, nurses also reported that they sometimes find

dislodged urinary catheters, gastrostomy tubes, oxygen, or patients in distress, which are only

discovered after the shift handoff at the nurse's station or medication carts have already been

completed. All these factors can contribute to errors and safety concerns that can ultimately

harm the patients. Nurses blame each other because of such incidents, which create tension and

conflicts among them. These factors can be attributed to the unit's high nursing turnover for the

first and second quarters of 2016. Newly hired nurses resigned prematurely because of the

conflicts, lack of support from the senior nurses, and miscommunication during the shift

handoffs.

Project Overview

The informal staff interviews and the results of the pre-implementation nurse satisfaction

survey revealed that most of the nurses are dissatisfied with the current shift handoff process in

the unit. Nurses believe that in an environment like the sub-acute unit, where most of the

patients require close monitoring, a standardized approach to shift handoffs must be

implemented to ensure safety and quality care. The majority of the patients in the unit use several medical devices that must be checked for accuracy of settings and correct placement. Given the complexity of the unit environment, standardizing the process of nurse-to-nurse shift report should be prioritized.

The project is designed to improve the communication and collaboration among the nurses during shift handoffs. Effective transfer of patient information from nurse to nurse is vital to ensure safety and positive patient outcomes. Wakefield, Ragan, Brandt, and Tregnago (2012) emphasized that bedside reporting has been linked to better patient involvement, improved effectiveness of communication among nurses, and enhanced nursing teamwork and accountability. By relocating the shift handoffs from the nurse's station to the patient's bedside, the patients can be more involved with their care, the nurses are better able to prioritize their tasks, and the nurses will no longer have to rely on the report given to them because both the outgoing and incoming nurses can compare their assessments. The goal of the project is to develop a standardized approach to nursing shift handoffs, which will be achieved by implementing the process of bedside reporting in the sub-acute unit.

The specific aim statement of the CNL project is to achieve an 80% nurse compliance with BSR and improve nurse satisfaction score with shift handoffs by 25% within 6 months. The overall global aim is to improve the nurse-to-nurse communication and collaboration during shift handoffs at Rosewood Care Center's sub-acute unit. Improving the nurses' communication will lead to improved safety and quality patient care, reduction in errors and near misses, greater nurse satisfaction, and eventually improve nurse retention in the unit.

Rationale

A comprehensive microsystem assessment was conducted in the sub-acute unit, which

revealed many communication gaps that can affect the delivery of patient care. During informal

staff interviews, many newly hired and even senior nurses have expressed their frustrations in the

way shift handoffs are conducted. According to the nurses, the information that they receive

from the outgoing nurses often does not match the patients' conditions. Nurses reported that

they may sometimes find a dislodged urinary catheter, intravenous (I.V.) line, and gastrostomy

tube, incorrect tube feeding formula infusing, disconnected oxygen, or a patient in distress,

which are often discovered only after the shift handoffs are completed, and the outgoing nurses

are no longer present in the unit. Situations like these can result in the receiving nurse getting

frustrated and getting behind with other tasks, which causes delay in care for other patients.

Oftentimes, the nurses are frustrated because they would have to stay overtime to finish the tasks

and the documentation. A root cause analysis was conducted to determine the causes of

ineffective communication during shift handoffs (See Appendix A). In addition, a SWOT

analysis was also created to determine the readiness of implementing BSR in the sub-acute unit.

(See Appendix B).

A pre-implementation survey was distributed among the nurses to assess their perception

and satisfaction with the current nurse shift handoff process (See Appendix C). The result of the

survey was not surprising at all based on the information obtained from the informal interviews.

The Likert-style survey consisted of questions asking the nurses to rate their satisfaction on the

effectiveness of prioritizing patient care, ability to ask questions during report, as well as

accuracy, efficiency, and consistency of the current shift handoffs. The pre-implementation

survey results revealed a low nurse satisfaction score of 61% (See Appendix D). A poor nurse

satisfaction score has negative implications in the quality of care, patient outcomes, and nurse

retention (Hairr, Salisbury, Johannsson, & Redfern-Vance, 2014). As stated previously, the unit

has had a high nursing turnover for the last 8 months. The sub-acute unit is always short of staff and the nurse manager or other department heads would sometimes need to work on the floor to administer medications. If this is not possible, the remaining nurses would need to divide the assignments and care for more patients than they can handle, which also affects nursing care. High nursing turnover leads to nursing shortages, which increases the workload placed on the remaining nurses in the unit (Hunt, 2009).

In addition to the poor nurse satisfaction score, there were 5 medication errors reported for the first 2 quarters of 2016 that were associated with the lack of communication among the nurses. Since the unit does not currently use the computer physician order entry system, the nurses often rely on the information in the physician order sheet, or the information given to them by the other nurses for any new physician's orders. The most common types of medication errors frequently encountered by the nurses in the unit consisted of the wrong time, frequency, dose, and omission errors. Medication errors caused by miscommunication between the nurses can have a negative impact on both the patient's quality of life and the institution's financial costs (Choi et al., 2016).

Financial Analysis

The projected costs for implementing the project include providing a short 20-30-minute introductory education and in-service training for the nurses. At this facility, an LVN receives an hourly rate of $26/hour, while an RN has a pay rate of $32/hour. There are a total of 19 nurses in the unit; therefore, the estimated cost for education and training would be $277. Follow-up training sessions will occur before, during, or after shift handoffs, or whenever the nurses have down time. We also have to consider the printing materials that will be needed to produce the template report. The estimated cost for the printing materials including paper and

toner are $450 for one year. See Appendix E for the financial analysis including the project costs breakdown.

Furthermore, BSR has many benefits to both the nurses and the facility including financial savings and staff satisfaction (Cairns, Dudjak, Hoffmann, & Lorenz, 2013). The BSR is more time-efficient than having the shift handoffs conducted at the nurse's station or in a conference room. In a study conducted by Evans, Grunawawlt, McClish, Wood, and Friese (2012), the authors reported that the average report time was reduced from 45 minutes to 29 minutes, one year after implementing BSR. In the sub-acute unit, the nurses tend to socialize at the nurse's station prior to conducting the report. Every shift has 4 nurses and there is usually an average of 15-30 minutes overtime for each nurse, which can add up to an estimated $64,800 of incidental overtime every year.

Poor nurse satisfaction can have an impact on nurse retention. The average length of stay for a newly hired nurse in the unit is only 4-8 weeks. The facility spent an estimated $52,600 for the last year just to rehire and retrain new nurses. In addition, medication errors can be associated with the lack or miscommunication between the nurses. According to Choi et al. (2016), treatment costs for a single incident of medication error even without significant harm to the patient is estimated to be $8,439. Therefore, if incidental overtime hours are reduced, medication errors are prevented, and nurses are retained, the facility can save as much as $125,112 every year. This means that implementing BSR can generate $173.09 for every $1.00 in cost. See Appendix E for financial analysis including Cost-Benefit Ratio.

Methodology

Relocation of nursing shift handoffs to the patient's bedside will be part of the institution's quality improvement initiative. Successful implementation of this project will lead

to an increase nurse satisfaction with shift handoffs, better delivery of patient care, and reduction in errors and near misses. The objectives of this project would be to achieve an 80% nurse compliance with BSR and improve nurse satisfaction score with shift handoffs by 25% within 6 months. The change theory that will be utilized to guide the implementation of this project is the Lewin's theory of planned change. The theory is relevant to my project because it was developed to better understand the change process and how to successfully plan and execute each step. Another factor that led me to this theory was the idea that the last stage deals with sustainability, which is very important in any change initiative project.

The theory involves three stages including unfreezing, moving or transitioning, and refreezing, which must be completed in order to ensure that change is successful (Shirey, 2013). According to Vines et al. (2014), "these stages outline activities related to educating and informing to change perspective, inspiring and directing new activities, and codifying and establishing a new set of norms postadoption" (p. 167).

Unfreezing

Unfreezing is the first stage of this process, which involves getting ready for the needed change. A microsystem assessment revealed that the majority of the nurses are dissatisfied with the current shift handoff process in the unit. In addition, during the informal staff interviews, many of these nurses have expressed their desire to change the way shift handoffs are conducted. The results of the nurse satisfaction surveys and the issue with the high nursing turnover were discussed among the nurses in the unit as well as with the nurse manager. Errors and near misses caused by miscommunication have made the nurses aware that change must be implemented in order to improve the delivery of patient care, which also facilitated buy-in from the staff. Standardizing the process of shift handoffs through BSR was presented to the staff as a possible

solution to the communication issues among the nurses. The majority of the nurses, especially

the newly hired nurses, believe that relocating the shift handoffs to the patient's bedside can

improve nurses' communication and collaboration, thus improving safety and quality of care.

Moving or Transitioning

This is the stage where the actual change in nursing practice occurs. Recognizing that

change is often difficult and chaotic is an important part of the process. Shirey (2013)

emphasized, "this stage necessitates creating a detailed plan of action and engaging people to try

out the proposed change" (p. 70). Nurses are more likely to comply with the proposed change if

they are part of the decision-making process and if they are aware of their individual roles. I

provided the nurses with initial education and training before, during, and after the shift

handoffs, and whenever they had down time. Additionally, it would be critical for the nurses to

receive continued support, guidance, and education until they become familiar with the process

of BSR. My role in the process is to serve as an expert educator, a guide, and a mentor to the

nurses. Identifying the key players would be beneficial to the success of this project to ensure

that implementation process is consistently applied. Fortunately, most of the staff nurses and the

unit nurse manager support the idea of BSR.

In addition to identifying key players, 3 staff nurses were selected, 1 nurse in each shift,

to serve as the unit champions. The unit champions will play a crucial role in the

implementation of the project, as they need to monitor the progress and the nurses' compliance

with BSR. They will also serve as role models, guides, and mentors to the rest of the nurses all

throughout the implementation process. Each unit champion will continue to educate and train

the nurses as needed until they begin to realize the value of this new practice.

Furthermore, prior to the actual pilot of the project, a two-week trial run would be

conducted to slowly introduce the nurses to BSR. During the BSR trial run, the nurses would

have the opportunity to ask questions and provide suggestions for improvement. The designated

unit champions and I would be present during these times to guide, educate, and provide

feedback as needed. This stage of Lewin's framework is often the most difficult stage for

participants to overcome, as it requires continued coaching and clear communication among

team members to prevent losing sight of the intended change (Shirey, 2013). Throughout the

process, it would be crucial to identify the potential barriers that can affect the successful

implementation of the project.

Moreover, it is important to inform the nurses about the steps and any changes that will

affect them. The flow chart was created for the nurses to better understand the steps and the flow

of the process (See Appendix F). The night shift nurses will initiate the template report that will

include any changes in patients' condition, urinary catheter output amount, correct tube feeding

formula and rate, mechanical ventilator settings and oxygen, IV fluids and medications, lab

results, and any other new orders (See Appendix G). The BSR will start at 0700 (between the

night and day shift), 1500 (between the day and pm shift), and 2300 (between pm and noc shift).

The unit has a 1:6 nurse-to-patient ratio, so the nurses should be able to finish the report in less

than 30 minutes, given that the report for each patient will take 3-5 minutes to complete. Both

the outgoing and incoming nurses will quickly assess the patient and the immediate environment,

making sure that the medical devices are checked for accuracy of settings and correct placement.

Any clarifications and questions about the patients and their care will be answered during this

time.

Refreezing

Finally, the last step of Lewin's theory is the refreezing stage. Everyone needs to

understand that BSR is now the newly accepted practice in the unit. Therefore, continued staff

education, guidance, and support are needed to ensure that nurses recognize BSR as the new

norm. The unit champions and I will continue to provide positive reinforcement that will

empower the nurses to remain active participants in the implementation of BSR. It is imperative

to constantly remind the nurses about the benefits of BSR to ensure that nurses will not go back

to the old ways of shift handoffs. As Shirey (2013) insisted, "the third stage is important because

locking in or institutionalizing change will be crucial to its sustainability over time" (p. 70).

Additionally, ongoing assessments will be needed to identify barriers and suggestions for

improvement, so the process can be modified as needed. I will distribute a post-implementation

nurse satisfaction survey 5 weeks and again 6 months after BSR pilot implementation in order to

reassess the nurses' perceptions with the new shift handoff process (See Appendix C). Other

data that will be reviewed on a regular basis will be the risk management report for medication

errors, nurse retention rate, and incidental nurse overtime. The nurse manager, the unit

champions, and I will help monitor the nurses' compliance with BSR as well. I have created a

tool that will assist us in tracking the nurses' compliance with BSR (See Appendix H). I predict

that nurses are going to comply with this new practice, as most of them have already verbalized

their intention to participate. Although I know that change is difficult and a slow process, I

believe that nurses will be satisfied with bedside reporting once they see the positive results of

this project, such as improvement in communication and reduction of medication errors and near

misses. My predictions will be compared to the results of the post-implementation nurse

satisfaction survey and other relevant data that will be collected throughout this process.

Data Source/ Literature Review

The goal of the literature review is to find the most up to date, relevant, and evidence-

based practice (EBP) articles that will support the CNL project. There is a growing body of

evidence suggesting that BSR can be used as a method to improve communication between the

nurses, thus enhancing safety and quality patient care. In addition, the data that will be presented

can be used to improve the unit's nurse satisfaction with nurse shift handoff process. I

conducted a literature search using CINAHL and Pub Med databases with the keywords *bedside*

report, bedside shift handoffs, nurse to nurse report, nurse satisfaction, patient satisfaction, and

nurse shift report. The search was limited to the most recent articles published within 2011-

2016, which yielded 87 potential relevant citations. For the purpose of this paper, 6 articles were

reviewed thoroughly.

PICO Statement

The PICO statement used in the literature search was as follows:

- P- Nurses in the sub-acute unit

- I- Nurse shift handoffs at the patient's bedside

- C- Nurse shift handoffs at the nurse's station or by the medication cart

- O- Reduction in medication errors and near misses, improves nurse and patient

  satisfaction, improves the delivery of safe and quality care, greater nurse and

  patient involvement, increases nurse accountability, improves teamwork and

  collaboration

Cairns et al. (2013) utilized the process of BSR as part of a quality improvement project

on a 23-bed inpatient unit. To evaluate the usefulness of BSR, the authors assessed several

indicators including nurse overtime, call light usage, nurse satisfaction, and patient satisfaction.

The authors confirmed positive correlations between bedside report and the indicators used for

this project. After 3 months of BSR implementation, end-of-shift overtime has decreased from

6,194 minutes to 5,281 minutes, a total of at least 15% difference. Cairns et al. (2013) believe

that a 10-minute decrease in incidental over time can help the unit save as much as $24,000 to

$36,000 in salary expenditure every 3 months. The call light usage decreased by an average of

33%, which can be attributed to nurses being accessible by the patients during shift changes

(Cairns et al., 2013). As a result, patients felt more involved and included in their care. In

addition, nurses noted that the information is more accurate and consistent following the BSR

implementation and 50% of the staff believed that teamwork and accountability have improved

because there was more collaboration among the nurses.

Effective communication among healthcare professionals is an important component of

safe and effective care. Evans et al. (2012) explored the barriers to effective change of shift

handoffs and found that traditional shift handoffs often occur at the nurse's station or behind

closed doors. Factors that affect the successful transfer of patient information from nurse-to-

nurse include noisy environment, interruptions from other staff, lack of standardized reporting

process, and incomplete and inaccurate information. Staff often leave late as they have to wait to

give the report to the nurses who frequently socialize and gossip prior to the shift handoffs. A

change in the process of shift handoffs was proposed to improve nurse-to-nurse communication

in a 32-bed medical surgical unit at the University of Michigan Hospital. The authors identified

BSR as one effective strategy to achieve desired outcomes that include improved patient care and

staff satisfaction. Evans et al. (2012) confirmed that BSR enabled the nurses to assess the patient

and the environment in a consistent manner. Nurses were able to assess I.V. lines, medications

that are infusing, and fluids and pump rates in real time. They reported a reduced average report

time from 45 minutes to 29 minutes. In addition, nurse satisfaction with reporting process rose

from 37% to 78% (Evans et al., 2012).

Considering the complexity of healthcare today, a standardized approach to shift handoffs must be prioritized in order to ensure patient safety. Motivated by the continued increase in medication errors and patient adverse events attributed to communication failures, The Joint Commission developed a guideline supporting the use of BSR as a strategy to improve patient safety (Gregory, Tan, Tilrico, Edwardson, & Gamm, 2014). The authors studied evidence-based articles supporting the use of bedside reporting as a practice to bridge the gaps in communication between healthcare professionals. The authors noted several evidence-based articles indicating that BSR has reduced possible medical errors. Of the 29 articles reviewed to assess the individual benefits of BSR, 31% cited an increase in communication and accuracy of patient information (Gregory et al., 2014). Based on their findings, nurses were able to ask questions and provide feedback without interruptions. Nurses were also able to immediately visualize the patient and ensure the accuracy of information by being able to compare both the outgoing and incoming nurses' assessments. The authors also emphasized that patients feel safer when they see two nurses communicating and collaborating about their care and being able to ask them questions.

Jeffs et al. (2013) conducted a qualitative study in one of the inner cities' acute care teaching hospital to evaluate the effectiveness of BSR. Included in the study were the units that have either already implemented the BSR, or those units that are planning to implement BSR. Interview sessions were conducted to evaluate the nurses' perceptions on BSR after implementation. The nurses who participated in the study concluded that BSR allowed them to clarify information related to the patients' condition. By being able to clarify information and check the patients in real time, both nurses and patients were able to recognize and correct possible and actual errors right away. Errors and near misses that were caught and corrected on

time were associated with medications, labs, and procedures. In addition, another positive

outcome of BSR is the nurses' ability to quickly assess the assigned patients and prioritize

patient care more efficiently.

Thomas and Donobue (2012) pointed out that effective nursing handoffs foster continuity

of patient care and safe transfer of the patient from nurse to nurse. With the goal to standardize

handoff reports and improve patient care and safety, the authors performed a study to redesign

intershift handoff through bedside report. Eight different hospitals volunteered to participate in

the pilot implementation of BSR in their medical-surgical and telemetry units. Baseline patient

satisfaction was obtained using the Press-Ganey survey as well as the nurse satisfaction score.

Thomas and Donubue (2012) noted the importance of the team members, as practice changes

require buy-in from all the members. Therefore, understanding the barriers to implementation

must be reviewed. Barriers perceived by the members include time to complete the report and

privacy issues. The authors indicated that sharing personal experiences and success stories

facilitated the implementation of BSR and helped mitigate these barriers. Additionally, new

graduate nurses were particularly satisfied with the new practice because they felt more

empowered about being able to competently care for their patients. With the shift handoffs being

conducted at the bedside, the patients were given the opportunity to be active participants, ask

questions, and be more involved in their care. Finally, the nurses reported an increase in

awareness about priorities and the ability to clarify and ask questions before assuming care of the

patients.

Ofori-Atta, Binieda, and Chalupka (2015) examined the use of bedside report as an

essential standardized process of shift handoff that promotes safety and quality patient care.

Traditionally, change-of-shift report occurs at the nurse's station or in the conference room,

which can take an hour or more to complete. Consequently, patients are usually alone while the

nurses finish their report. Ofori-Atta et al. (2015) argued that patient adverse events or sentinel

events are more likely to occur during this alone time. Therefore, the use of BSR is highly

recognized as an effective tool to reduce the risk of errors and improve nurse-to-nurse

communication. If shift handoffs are performed at the patient's bedside, both nurses can easily

verify information including pump settings, I.V. medications, and possible drug reactions.

Additionally, both nurses can also compare their assessments and note any new pressure ulcers,

assess surgical wounds for bleeding or infections, and check the patients' environment and

overall appearance.

Timeline

The Gantt chart illustrates the specific time frame for each step in the implementation of

BSR in the sub-acute unit (See Appendix I). A microsystem assessment including informal staff

interviews was initially conducted in July 2016 to identify the need for this project. A review of

the facility's risk management report was done to determine if there was any data available to

support my project. In addition, a pre-implementation survey was created and distributed in

August 2016, to assess the nurses' perceptions of the current shift handoff process in the unit.

Additionally, EBP research development started at the end of July 2016 and continued on until

September 2016. After data and nurse satisfaction results had been analyzed, the project was

presented and discussed with the unit's nurse manager in August 2016, with the approval to

implement BSR in September 2016.

The BSR implementation process started on September 6, 2016, and will continue on

until March 2017. This process includes providing in-service and training to the nurses, BSR

trial run, and the pilot and formal BSR implementation. A post-implementation survey will be

distributed 5 weeks after the pilot of BSR to assess nurse satisfaction score improvements and to

determine if modifications in the process are needed. Post data collection and analysis will occur

all throughout the BSR implementation process. Another post-implementation survey will be

distributed in March 2017, 6 months post BSR adoption, to reassess nurses' perceptions on the

new shift handoff process. Other data to assess post BSR adoption include reviewing the risk

management report for trends and rates of medication errors, and any patient adverse events

related to staff miscommunication. Finally, a proposal to revise the current policy on nurse shift

handoffs, which will now include bedside report, will be submitted for review and approval in

January 2017 after the annual state survey.

Expected Results

Standardizing the process of shift handoffs through the utilization of bedside report is an

effective approach to improve the communication and collaboration among the nurses. By

improving the effectiveness of communication among the frontline nurses in the unit, the

delivery of safe and quality care should also improve. The initial survey results showed that the

nurses are dissatisfied with the quality and accuracy of shift handoffs in the unit. In addition, the

majority of these nurses have expressed their desire to change the way shift handoffs are

conducted. Change is difficult and often chaotic so resistance from some of the nurses is

expected. Therefore, it is imperative to provide continued support, education, and guidance,

until the nurses begin to realize the value of the new nursing practice. With the dedication of the

team members and the management, it is definitely possible to make the change a success.

The expected results of this project are improvements in nurse satisfaction with shift

handoffs, reduction of errors and near misses caused by miscommunication among the nurses,

and increased compliance with BSR. With the successful implementation of this project, I

expect that nurse satisfaction will increase from 62 % to at least 90% within 6 months, even

better that my specific aim. I also expect that at least 80-90% of the nurses will comply with this

new practice within 6 months. Additional advantages of improved communication and

collaboration between the nurses are the reduction of incidental overtime and a greater nurse

retention. I am very optimistic that most of the nurses will embrace the change, as I am already

receiving positive feedback from them.

Nursing Relevance

The results of this project will enhance awareness on the importance of effective

communication and collaboration among the nurses and other healthcare professionals in

ensuring safety, quality, and effective patient care. As the healthcare arena continue to evolve

and become more complex, it is essential for the nurses to become part of the innovations that

will promote a safe environment for the patients. The use of an evidence-based approach, such

as BSR, can enhance the accuracy, consistency, and efficacy of nurse-to-nurse communication.

The population that we serve in the sub-acute unit requires frequent monitoring to ensure

well-being. Every patient in the unit has several medical devices including a mechanical

ventilator, oxygen, urinary catheter, gastrostomy tube, and I.V. pumps, which must be checked

for accuracy of settings and correct placement. Successful implementation of BSR in the unit

will decrease preventable errors that can potentially cause patient harm. This process will also

improve nurses' collaboration, accountability, and teamwork. In addition, patients will become

more empowered to take an active role in the decision-making process related to their care. As a

result, the standardization of shift handoffs will help achieve a high-quality care and positive

patient outcomes.

Summary Report

The overall global aim of this project was to improve the nurses' communication and collaboration during shift handoffs. The goal was to develop a standardized approach to nurse-to-nurse communication through utilization of bedside shift report (BSR), which will ensure the delivery of safe, quality, and effective patient care. The specific aim statement was to achieve an 80% nurse compliance with BSR and improve nurse satisfaction score with shift handoffs by 25% within 6 months.

The CNL project was implemented at Rosewood Care Center's sub-acute unit located in Pleasant Hill, CA. This is a 27-bed unit with a population of adults over 18 years of age, which specializes in traumatic brain injury, post cardiac arrest, and acute and chronic respiratory failure care. The majority of the patient population is in a persistent vegetative state, all of the patients have a tracheostomy in place, at least 60% are on a mechanical ventilator for respiratory support, and most of the patients have a long-term feeding tube for nutrition and medications. The unit is very complex and fast paced, as the majority of the patients require close monitoring and a 24-hour extensive assist nursing care. The staff is composed of the RNs, LVNs, RRTs, unit manager, PCAs, and nursing supervisor.

I used The Lewin's Theory of Planned Change as a framework to guide the implementation process of BSR in the unit. I conducted an initial microsystem assessment prior to implementing BSR. The assessment included informal staff interviews, pre-implementation nurse satisfaction survey, and a review of the risk management report for medication errors. The results of the interview and the survey revealed that the majority of the nurses were dissatisfied with the previous shift handoff process, which was being conducted either at the nurse's station or by the medication cart. Additionally, five medication errors were reported for the first and second quarters of 2016, which were associated with communication breakdowns among the

nurses. The main motivations for BSR implementation were the patient adverse events,

medication errors, the lack of accuracy, consistency, and effectiveness of the previous nurse shift

handoffs, as well as the low nurse satisfaction score of 61%.

After analyzing the baseline data and reviewing the relevant literature, I proposed BSR to

the unit's manager as a method to improve communication between the nurses during shift

handoffs. Upon obtaining an approval from the unit's manager to implement the project, I

immediately collaborated with the nurses and informed them about the upcoming change in

nursing practice. The nurses were provided education and training, including a discussion about

the benefits of BSR, the tools that would be used during the process, and a demonstration on how

to conduct BSR properly. To make the process more effective, I provided the nurses with the

education and training in small group sessions, before and after shift handoffs, or whenever the

nurses had downtime. In addition to the current staff nurses, the two new nurses who were hired

during the second week of October, after BSR had already started, were also provided with the

same education and training. As expected, the nurses were very receptive to the idea of

relocating the shift handoffs to the patient's bedside. To my pleasant surprise, the majority of the

nurses were already aware of the benefits of BSR, including the ability to receive a more

accurate and consistent patient information, the ability to immediately visualize the patient and

the environment, the ability to check the medical devices for accuracy of settings and placement,

the ability to leave the unit on time because of less socialization, and the ability to prioritize

patient care (Evans, et al., 2012; Tan, 2015). Additionally, three staff nurses, one nurse in each

shift, were selected to serve as the unit champions to assist with BSR implementation. The unit

champions were such a big help, as they provided additional guidance, support, and

reinforcement to the staff nurses. They also assisted in monitoring the nurses' compliance with

BSR due to the fact that I was not in the unit every day.

Prior to the pilot of BSR on September 21, 2016, a 2-week trial run was conducted to

slowly introduce the nurses to the new process and to see if modifications were needed to

strengthen the implementation of BSR. I had the pleasure to observe the nurses during the trial

run and to provide them with additional guidance, education, and support. The nurses also had

the opportunity to ask me questions and provide suggestions for improvement. Furthermore, I

created a report template tailored for the sub-acute unit to replace the old blank sheet that the

nurses were using during shift handoffs. The new report template included information such as

new medication orders, ventilator settings, supplemental oxygen, gastrostomy tube feeding type

and rate, urinary catheter output, allergies, code status, labs, PRN meds, current vital signs, and

I.V. meds/fluids (See Appendix G). This report template is an additional tool that could assist

the nurses to organize the information that will be communicated during BSR.

In addition to the new report template, I also developed a compliance monitoring tool to

assist in monitoring the nurses' compliance with BSR. Aside from myself doing the monitoring,

the unit champions were also given a copy so that they could help me track the nurses'

compliance (See Appendix H). The handouts, including the new report template, BSR flow

chart, and the compliance monitoring tool were used as teaching aids for this project. No

additional changes were made from the prospectus so that I could stay on track with my CNL

project.

The evaluation process consisted of distributing a post-implementation nurse satisfaction

survey, a review of the risk management report for medication errors, and a direct observation of

the nurses during BSR. The same nurse satisfaction survey (Appendix C) was used to obtain the

data pre and post BSR implementation. I am pleased to note that within a short period of time,

there was already an improvement in nurse satisfaction score. The results of the post-

implementation survey revealed an improvement in nurse satisfaction score from 61% to 73%

after five weeks of BSR implementation (See Appendix K). After comparing the pre-

implementation and the post-implementation nurse satisfaction survey results, I noted

improvements in all areas assessed in the survey (See Appendix J). Finally, a review of the most

recent risk management report also revealed that there was a significant decrease in medication

errors, which showed no medication errors were reported from September 21st to October 31st.

While the process of BSR may not be directly related to the decrease in medication errors, the

improvement of the nurses' communication during shift handoffs could definitely have impacted

this positive result. The early results of my project were very promising, so I am confident that I

could achieve the stated specific aim of this project within six months.

　　　　While conducting my observations during BSR, I noted improvements in communication

among the nurses. The transfer of patient information during shift handoffs became more

accurate and consistent because of the standardized process. Surprisingly, the average time for a

shift report when conducted at the patient's bedside was less than 25 minutes, better than I

expected. This was due to the fact that the nurses had less time to socialize and gossip at the

nurse's station. In addition, the nurses were able to ask questions pertinent to the patient because

they had extra time to collaborate and clarify information. Moreover, a couple of the staff nurses

informed me that during the first week of BSR implementation, they had already intercepted two

potential errors and near misses. Upon performing BSR, the nurses were able to catch the wrong

gastrostomy tube feeding formulas infusing. As a result, the nurses were able to replace the

correct feeding formulas without any delays or complications. Since the new report template

includes the majority of the information pertinent to the patient, both nurses could easily

compare the orders and relay more accurate and complete information during BSR.

Additionally, the process of BSR also provided the nurses the opportunity to check other lines

such as the urinary catheter, long-term tube feeding, mechanical ventilator, oxygen, and I.V. site,

without having to wait for the outgoing nurses to leave the unit. Lastly, there was also an

improvement in how nurses prioritize patient care because they could immediately visualize the

environment and the patient in real time and compare their assessments, thus making it easier for

them to prioritize tasks better.

As I expected, the nurses' compliance with BSR during the month of October (1st-31st)

was 70% (See Appendix L). The unit continued to have problems with staffing because of the

nursing shortages in the unit, which was the major barrier to BSR implementation. Nursing

shortages in the sub-acute unit negatively affected the staffing, which sometimes led to the

nurses' non-compliance with BSR. Unfortunately, there were times when the nurses did not

perform BSR because they were either short of staff or some nurses had to work double shifts. If

one of the nurses had to work double shifts, BSR was not possible because that same nurse had

to work until the next shift, so there was no one to conduct BSR with. Also, there were times

when the nurses had to divide the patient's assignments among the remaining nurses because the

unit was short of staff, which meant the nurses had to care for more patients than usual. As

much as the nurses wanted to perform BSR, they felt that it was not possible because they had to

sometimes rush the report in order for them to start their tasks on time. Although this was a

problem to some nurses, many of the staff were able to perform BSR and were still able to finish

on time, even if they were short of staff. This served as a motivation to some of the nurses who

were initially hesitant to perform BSR because of the problem with staffing. So, I'm optimistic

that the rest of the nurses will follow through with the process in spite of the issues with staffing.

Sustainability Plan

In order to sustain this improvement project, BSR would need to be included as part of

the unit's new policy. The nurses will be likely to comply with BSR if they know that a policy is

in place because they are required to follow that policy. Revision of the current policy will need

to undergo a thorough review by the corporate office, so it will take a couple of months before it

can be approved. In addition, the facility is currently busy preparing for their annual state survey

visit, so another proposal will need to be submitted in January 2017. Fortunately, the unit nurse

manager was very open to the idea of revising the current policy in order to sustain the project.

Furthermore, my sustainability plan relies heavily on the unit champions and the unit manager,

as they must continue to provide the nurses' with ongoing education, guidance, support, and

positive reinforcement. I am very confident that the unit can sustain this new practice, as the

majority of the nurses have already started to see the benefits and the positive results of BSR.

The perceived benefits of the staff will help sustain BSR as the primary method of

communication during shift handoffs. Finally, if the problem with staffing can be improved and

resolved, the nurses will have the motivation to continue to use BSR. So far, the unit has just

hired two full-time nurses and will hire five more nurses in the coming weeks to improve the

staffing in the unit.

In conclusion, one of the most important lessons I learned throughout the implementation

of this project was that collaboration with the stakeholders was the key to success. Without the

help of my preceptor, the unit champions, the unit manager, the management, and the dedicated

frontline nurses in the unit, this project would not have been possible. This CNL project has

taught me that changing the unit's practice can be challenging, sometimes chaotic, but the nurses are always willing to do what it takes to improve the quality of care and patient outcomes. The practicum experience provided me the opportunity to "facilitate practice change based on best available evidence that results in quality, safety, and fiscally responsible outcomes" (AACN, 2013, p. 13). The transfer of critical information and the responsibility for the care of the patients from one nurse to another is an essential element of communication in healthcare; therefore, it must be accurate, complete, and consistent (Jeffs et al., 2013). Finally, I truly believe that the process of BSR can help ensure the delivery of safe, effective, consistent, and quality patient care.

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Appendix A

Root Cause Analysis: Fishbone Diagram
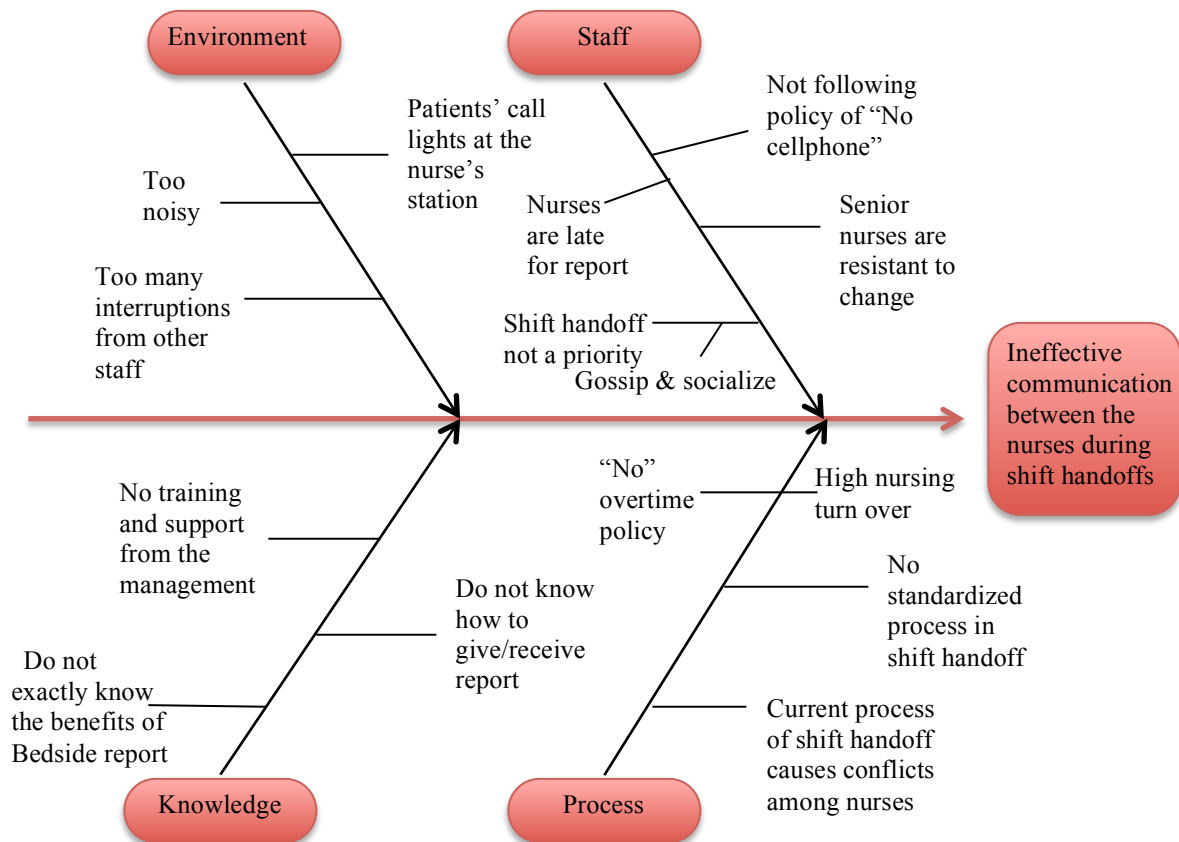
Note: The root cause analysis illustrates the causes of ineffective communication during shift

handoffs

Appendix B

SWOT Analysis

Positives	Negatives
Strengths -Many newly hire and licensed nurses in the unit who seem to adapt to changes fairly good -The unit manager supports nursing quality improvement initiatives -Low nurse-to-patient ratio in the sub-acute unit -Good teamwork among the staff and management	**Weaknesses** -High nursing and management turn over -The unit enforces "no overtime" policy -Lack of standardized shift handoff process -No policy for effective communication -Some nurses are always late for the change-of-shift report -The unit environment is too noisy with many interruptions from staff and call lights -Conflict and miscommunication among new nurses and senior nurses in the unit
Opportunities - High nurse and patient satisfaction will improve nurse shortage in the unit -Decrease in errors will lead to facilities financial gain -Model for practice change in other sub-acute unit in the area -Improve patient and nurse experiences	**Threats** -Advances in technologies and a changing healthcare environment, which can impact the delivery of patient care -Changes of the patient population in the unit (higher acuity) -Increase in patient admission -Changes in nurse-to-patient ratio -High nursing and management turnover, which means new nurses and management-potential for non-compliance -Lack of budget to support training and education session for the nurses

Note: The SWOT analysis illustrates the strengths, weaknesses, opportunities, and threats, to

evaluate the readiness of implementing BSR within the unit.

Appendix C

Nurse Satisfaction Survey

In an effort to improve nurse-to-nurse communication in the unit, I would like to get your feedback on how you feel about the way change-of-shift report is currently being performed in the sub-acute unit. Please respond to each question below.

1. The change-of-shift report starts and ends on time.

Completely Satisfied	Satisfied	Neutral	Dissatisfied	Completely Dissatisfied
1	2	3	4	5

2. The report I receive from the outgoing nurse match the patient's condition

Completely. Satisfied	Satisfied	Neutral	Dissatisfied	Completely Dissatisfied
1	2	3	4	5

3. The report I receive from the previous nurse is accurate, complete, and pertinent to the patients' condition.

Completely Satisfied	Satisfied	Neutral	Dissatisfied	Completely Dissatisfied
1	2	3	4	5

4. The outgoing nurse answers my questions about the patients, before I assume care of the patients.

Completely Satisfied	Satisfied	Neutral	Dissatisfied	Completely Dissatisfied
1	2	3	4	5

5. The report I receive allows me to efficiently and effectively prioritize patient care

Completely Satisfied	Satisfied	Neutral	Dissatisfied	Completely Dissatisfied
1	2	3	4	5

Job title: RN___ LVN___　　　Date:_____

Thank you for your participation! Francis Estrella, RN, MSN-CNL student

Note: Adapted from Evans et al., 2012. The nurse satisfaction survey was distributed prior to BSR implementation. The same survey will be utilized to reassess nurse satisfaction post BSR adoption.

Appendix D

Nurse Satisfaction Survey Result

Pre-implementation Nurse Satisfaction Survey
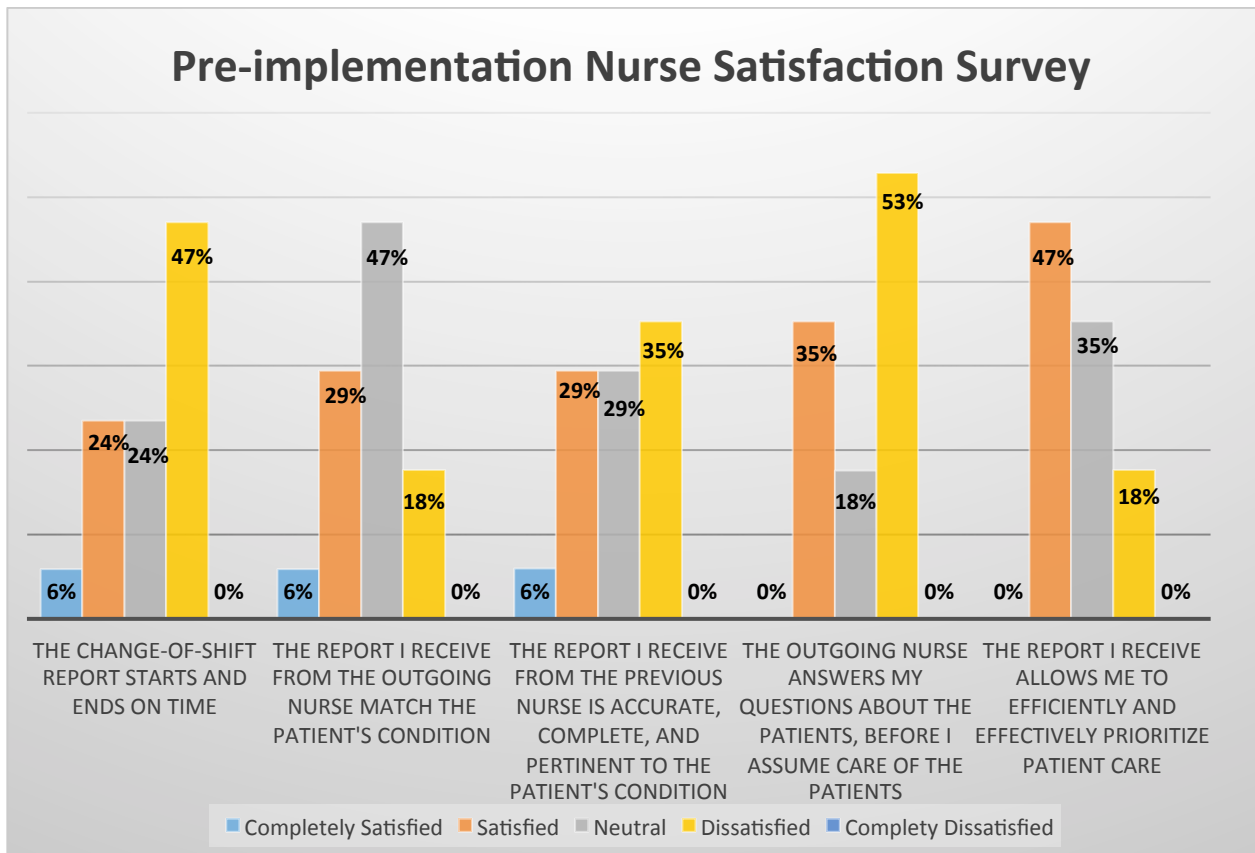
Note: Pre-implementation survey includes 5 Likert type questions. Each answer was given a numeric value (completely satisfied= 100 pts, satisfied= 80 pts, neutral= 60 pts, dissatisfied= 40 pts, completely dissatisfied= 20). The total number of nurses surveyed (n=17). I added all the scores from each question (5,200) and divided by the total points (8500). The overall nurse satisfaction score is 61%.

Appendix E

Financial Analysis

Items	Cost
Education and training for nurses LVNs= $26/hour x 9 x 30 minutes RNs= $ 32/hour x 10 x 30 minutes	$277
Printing Materials (toners and papers) for report template- per year	$450
CNL student providing education and training sessions	$0
Total Cost of BSR implementation	$727
Preventable Events	Benefits
One medication error	$8,439
Nursing turnover costs for the last 1 year	$52,600
Nurses overtime per year (min of 30 min per nurse/shift)	$64,800
Total Benefits	$125,839

Note: This illustrates the total cost of the project and the potential savings from preventable

events. The *net benefit*= $125,839-$727= **$125, 112**. Benefit-cost ratio: BSR can generate

$173.09 for every $1.00 in cost.

Appendix F

Bedside Shift Report Flow Chart

```
┌─────────────┐     ┌─────────────┐     ┌─────────────┐     ┌─────────────┐
│ Night shift │     │ Write down  │     │ Bedside     │     │ Outgoing and│
│ to fill out │ ──▶ │ new MD      │ ──▶ │ report      │ ──▶ │ incoming    │
│ report      │     │ orders, lab │     │ starts at   │     │ nurses to   │
│ template    │     │ results,    │     │ 0700, 1500, │     │ report at   │
│             │     │ patient'    │     │ and 2300 on │     │ the pt'     │
│             │     │ assessment  │     │ a daily     │     │ bedside     │
│             │     │             │     │ basis       │     │             │
└─────────────┘     └─────────────┘     └─────────────┘     └─────────────┘
```

```
┌─────────────┐     ┌─────────────┐     ┌─────────────┐     ┌─────────────┐
│ Introduce   │     │ Nurses to   │     │ Verify and  │     │ Compare     │
│ incoming    │ ──▶ │ assess      │ ──▶ │ assess IV   │ ──▶ │ assessments │
│ nurse to the│     │ patient's   │     │ lines, meds,│     │ of outgoing │
│ patient and │     │ environment │     │ ventilator, │     │ and incoming│
│ family      │     │             │     │ o2, etc     │     │ nurses      │
└─────────────┘     └─────────────┘     └─────────────┘     └─────────────┘
```

```
┌─────────────┐     ┌─────────────┐     ┌─────────────┐     ┌─────────────┐
│ Discuss     │     │ Bedside     │     │ Answer      │     │ Receive     │
│ sensitive   │ ──▶ │ report      │ ──▶ │ incoming    │ ──▶ │ accurate and│
│ info outside│     │ should take │     │ nurse'      │     │ complete    │
│ pt's room   │     │ less than   │     │ questions as│     │ report      │
│ for HIPAA   │     │ 5 min. for  │     │ needed      │     │             │
│             │     │ each pt     │     │             │     │             │
└─────────────┘     └─────────────┘     └─────────────┘     └─────────────┘
```

```
                                                            ┌─────────────┐
                                                            │  Outgoing   │
                                                            │   nurse     │
                                                            │  leaves on  │
                                                            │    time     │
                                                            └─────────────┘
```

Appendix G

Sub-acute Template Report

Pt name: **Rm #**	**Pt name:** **Rm #**
Dx:	**Dx:**
Code Status: **Allergies:**	**Code Status:** **Allergies:**
G-T Formula/Rate/Frequency:	**G-T Formula/Rate/Frequency:**
V/S: **BG**:	**V/S**: **BG**:
Trach size/Sx:	**Trach size/Sx:**
O2: **Vent settings:**	**O2**: **Vent settings:**
I:____O:____ **Last BM:**	**I:____O:____** **Last BM:**
New MD orders:	**New MD orders:**
IV (SITE/IVF/ATB):	**IV (SITE/IVF/ATB):**
Labs/Results:	**Labs/Results:**
PRN meds given:	**PRN meds given:**
Pt name: **Rm #**	**Pt name:** **Rm #**
Dx:	**Dx:**
Code Status: **Allergies:**	**Code Status:** **Allergies:**
G-T Formula/Rate/Frequency:	**G-T Formula/Rate/Frequency:**
V/S: **BG**:	**V/S**: **BG**:
Trach size/Sx:	**Trach size/Sx:**
O2: **Vent settings:**	**O2**: **Vent settings:**
I:____O:____ **Last BM:**	**I:____O:____** **Last BM:**
New MD orders:	**New MD orders:**
IV (SITE/IVF/ATB):	**IV (SITE/IVF/ATB):**
Labs/Results:	**Labs/Results:**
PRN meds given:	**PRN meds given:**

Note: The template is tailored for the sub-acute unit that will be used during BSR.

Appendix H

Compliance Monitoring Tool

Oct-16	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
NOC TO DAY																															
Team 1																															
Team 2																															
Team 3																															
Team 4																															
DAY TO PM																															
Team 1																															
Team 2																															
Team 3																															
Team 4																															
PM to NOC																															
Team 1																															
Team 2																															
Team 3																															
Team 4																															

* Designated Unit Champions, Nurse Manger, and the CNL student will check the nurses' compliance with BSR every shift

✔ =Indicates that nurses performed BSR   ✘ =Indicates that nurses did not perform BSR

Note: This tool will be utilized to monitor the nurses' compliance with BSR.

Appendix I

Bedside Report Project Timeline

Task Name	Start Date	End Date	Duration	Assigned To
Microsystem Assessment	**07/11/16**	**09/05/16**	**41d**	
Informal Staff Interviews	07/11/16	07/15/16	5d	CNL student
Data Collection	08/24/16	08/31/16	6d	CNL student & unit manager
Pre-implementation Survey	08/30/16	09/01/16	3d	CNL student
Data Analysis	09/02/16	09/02/16	1d	CNL student
Research and EBP development	07/29/16	09/05/16	39d	CNL student
Project Proposal to Unit Manager	08/24/16	09/02/16	10d	CNL student & unit manager
Bedside Report Implementation	**09/06/16**	**03/27/17**	**203d**	
Nurse In-service and Education	09/06/16	09/09/16	4d	CNL student
BSR Trial Run/Observation/obtain nurses' feedback	09/07/16	09/20/16	23d	CNL student & unit champions & nurse manager
Pilot and formal BSR implementation	09/21/16	03/27/17	176d	CNL student & staff nurses
Evaluation	**10/25/16**	**03/29/17**	**167d**	
Post-implementation Survey (5 weeks)	10/25/16	10/28/16	3d	CNL student
Post-implementation Data Collection and Analysis	10/25/16	03/27/17	102d	Unit Manager & Unit Champions & CNL
Post-implementation Survey (6 months)	03/27/17	03/29/17	3d	unit manager & unit champions & CNL
BSR Policy Proposal (after the annual state survey)	01/31/17	05/31/17	121d	CNL, unit manager, Director of Nursing, corporate office

Appendix J

Post-implementation Nurse Satisfaction Survey Result

Post-implementation Nurse Satisfaction Survey
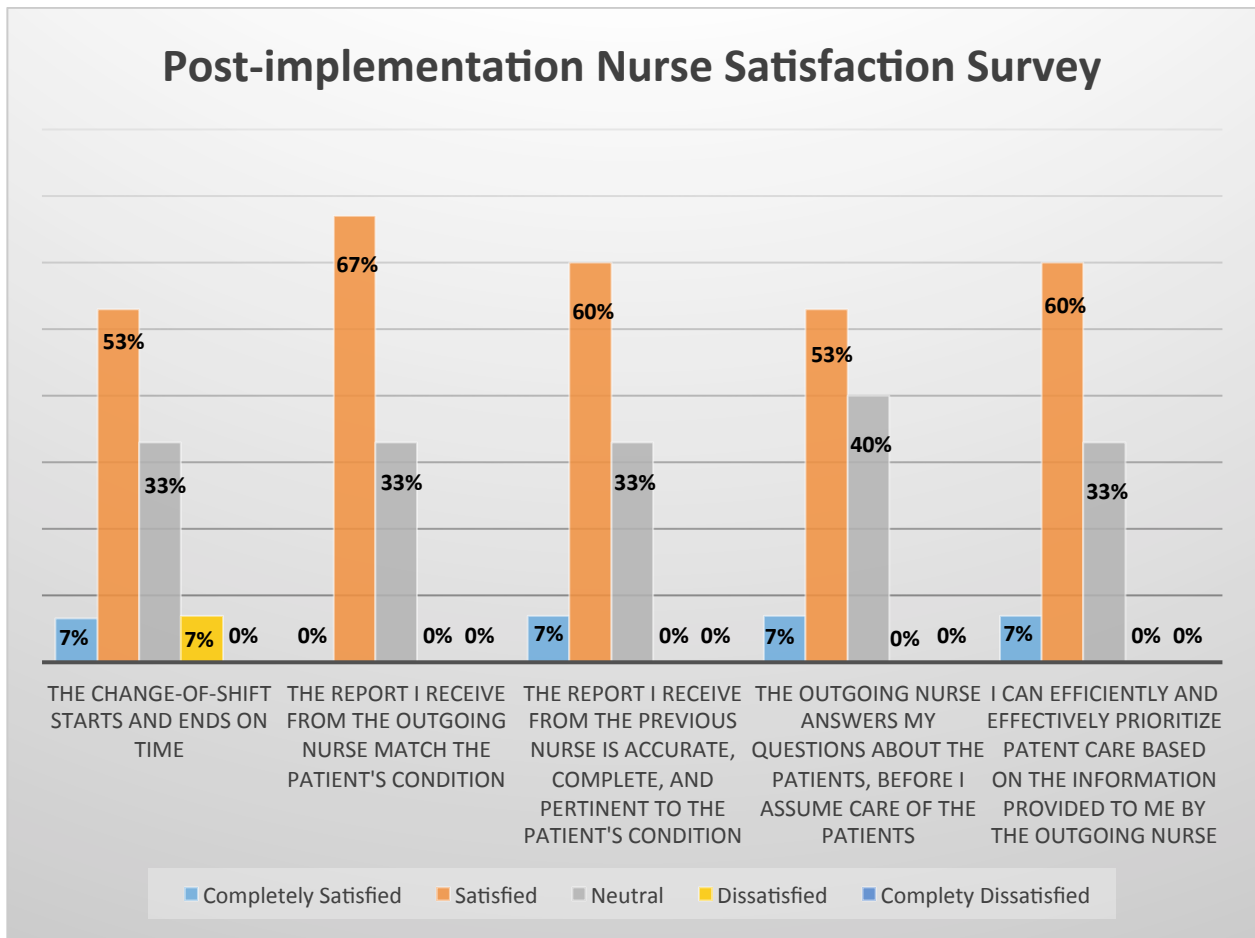
Note: The chart illustrate the results of nurse satisfaction survey 5 weeks post BSR implementation. Each answer was given a numeric value (completely satisfied= 100 pts, satisfied= 80 pts, neutral= 60 pts, dissatisfied= 40 pts, completely dissatisfied= 20). The total number of nurses surveyed (n=15). I added all the scores from each question (5,500) and divided by the total points (7,500). The overall nurse satisfaction score is 73%.

Appendix K

Results of Nurse Satisfaction Pre/Post BSR implementation
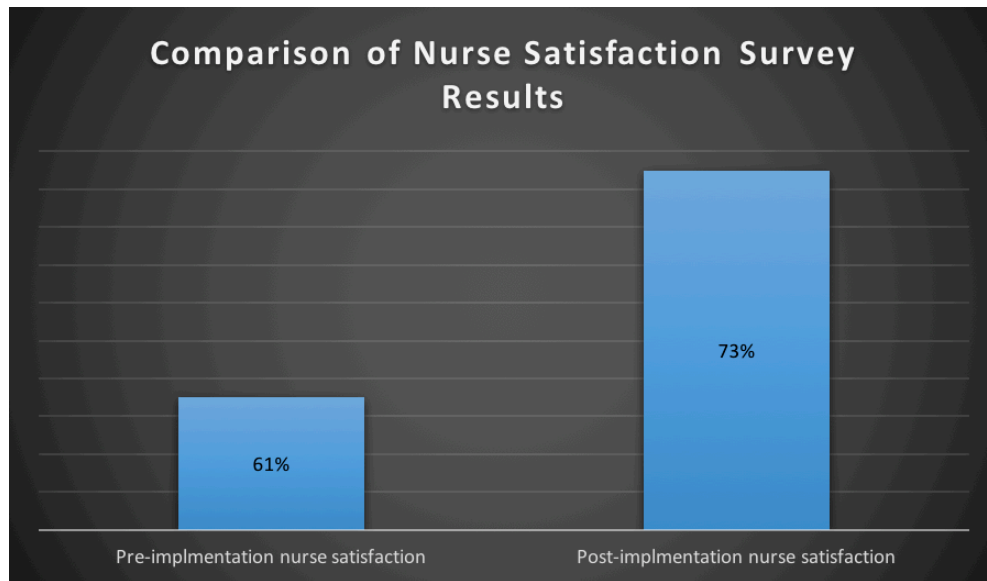
Note: The chart illustrates the comparison of nurse satisfaction rate before and 5 weeks after

BSR implementation.

Appendix L

Compliance Report

Oct-16	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
NOC TO DAY																															
Team 1	✔	✘	✔	✔	✘	✔	✔	✔	✘	✔	✔	✔	✘	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✘	✔	✔	✔	✘	✔	✘	✘
Team 2	✔	✔	✘	✘	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✘	✔	✘	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Team 3	✔	✔	✘	✔	✔	✔	✔	✘	✔	✘	✔	✔	✔	✔	✘	✔	✔	✘	✘	✘	✔	✔	✔	✘	✔	✔	✘	✔	✘	✘	✔
Team 4	✘	✘	✔	✔	✔	✔	✔	✘	✔	✔	✘	✔	✔	✔	✔	✔	✘	✘	✔	✔	✔	✔	✔	✘	✔	✘	✔	✔	✔	✔	✔
DAY TO PM																															
Team1	✘	✔	✘	✔	✔	✘	✔	✔	✔	✘	✔	✔	✔	✘	✘	✔	✘	✘	✔	✔	✔	✔	✔	✔	✔	✘	✔	✔	✔	✘	✔
Team 2	✘	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✘	✔	✔	✔	✔	✔	✘	✔	✔	✘	✔	✔	✔	✔	✘	✔	✘	✔
Team 3	✔	✘	✔	✘	✔	✔	✘	✘	✘	✘	✔	✔	✘	✔	✘	✔	✘	✔	✘	✔	✔	✔	✘	✘	✔	✔	✔	✔	✔	✔	✘
Team 4	✔	✔	✘	✔	✔	✔	✔	✔	✔	✘	✔	✔	✘	✔	✔	✔	✘	✘	✔	✔	✘	✘	✘	✔	✔	✔	✔	✘	✔	✘	✔
PM to NOC																															
Team 1	✔	✔	✘	✔	✔	✔	✔	✔	✔	✔	✘	✔	✘	✔	✘	✘	✔	✔	✘	✔	✔	✔	✘	✔	✔	✔	✘	✔	✔	✘	✔
Team 2	✘	✔	✘	✔	✘	✘	✔	✘	✔	✘	✔	✘	✔	✔	✘	✔	✔	✘	✘	✔	✔	✘	✔	✔	✘	✘	✔	✔	✘	✘	✔
Team 3	✔	✘	✔	✔	✔	✔	✘	✘	✔	✔	✔	✔	✘	✔	✘	✔	✔	✘	✘	✔	✔	✔	✔	✘	✘	✔	✘	✔	✘	✔	✔
Team 4	✔	✔	✔	✔	✔	✔	✔	✘	✔	✘	✔	✔	✔	✔	✔	✘	✔	✔	✘	✔	✔	✘	✔	✔	✘	✔	✔	✔	✘	✔	✔

* Designated Unit Champions, Nurse Manger, or the CNL student will check nurses' compliance with BSR indicating whether the shift handoffs occur at the patient's bedside during change of shift

✔ =Indicates that nurses performed BSR   ✘ =Indicates that nurses did not perform BSR

Note: The chart illustrates the nurses' compliance with BSR for the month of October. The total number of times that the nurses performed BSR divided by the total number of times that the nurses were expected to perform BSR: 260/372=**70%**