Summer 8-31-2020

Standardizing the Bedside Shift Report: Improving Communications and Promoting Patient Safety

Chona C. Alforque
ccal4k@gmail.com

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Chona C. Alforque

University of San Francisco

Abstract

PROBLEM: Nursing shift reports are integral to nursing as they allow for the transfer of critical information and responsibility of patient care from one nurse to another. Ineffective communication during shift-to-shift reports can contribute to gaps in patient care and breaches in patient safety, including medication errors, falls, and sentinel events. The greatest risk of communication breakdown is during transitions in care.

CONTEXT: St. Louise Regional Hospital, a small community hospital, consisting of an eight-bed medical-surgical intensive care unit lacked structure in how handoff should occur and had variances in shift handoffs. Observation of the shift handoff at the nurses' station revealed many communication gaps that have shown negative impacts on patient safety and outcomes. The improvement project described in this paper focused on evidence-based practices that support the benefits of bedside shift and implementations of standardized handoff tools.

INTERVENTION: Intervention included an education in-service for unit managers, educational coordinators, and staff nurses to emphasize the important benefits of bedside shift report.

MEASURES: The three components for evaluating improvement include outcome, process, and balancing measures to determine whether the improvement project has had the desired impact. The outcome measure expected to yield the following: direct observation of nurses during bedside report to calculate how often is being done, monitor for decrease in overtime due to more efficient shift-to-shift bedside reports, and a review of risk management reports observing for effect on the number and severity of medication errors.

RESULTS: The outcome measure is to increase the nurses' compliance with bedside shift report in the intensive care unit to at least 80% within six months of implementation.

CONCLUSION: With the proposed change, bedside shift report will addresses all the safety hazards by reducing adverse events, such as medical errors, patient falls at shift change, and sentinel events. Bedside shift report improves patient safety, enhances the quality of care, improves patient and nurse satisfaction, decrease unnecessary healthcare expenditure, and saves time.

Keywords: bedside shift report, patient safety, communication, handoff, patient satisfaction

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Introduction

In today's health care environment, patients present challenging medical conditions and volumes of patients are on the rise. Hospitals are seeing an increasing trend towards interpersonal communication such as verbal, non-verbal, and written communication between nurses and other interdisciplinary care teams, requiring essential information to be communicated when transitioning patients between care settings. Ineffective communication on patient handoff is often the root cause of sentinel incidents in intrahospital patients. More than 3,000 sentinel events analyzed from 1995 to 2004 revealed that 65% were caused by ineffective communication (Johnson, Logsdon, Fournier, & Fisher, 2013). A recent study by The Joint Commission (2106) estimated that communication failures in U.S. hospitals and medical practices were responsible for 30% of all malpractice claims, resulting in 1,744 deaths and $1.7 billion in malpractice costs over five years. In response to these findings, The Joint Commission (2017) developed a National Patient Safety Goal that requires healthcare organizations to implement standardized communication processes for handoff to protect patient safety and provide an opportunity for discussion between the giver and the receiver of information.

This project focuses on standardizing bedside shift report (BSR) to improve communication and promote patient safety. Bedside shift reporting is one nursing intervention that has not been initiated to the St. Louise Regional Hospital (SLRH) intensive care unit. One strategy that would be beneficial in the implementation of bedside shift reporting is educating the staff on the evidence-based practices that have improved the quality of care for patients. In addition, educating the staff will help alleviate some of the variances in different communication

styles, barriers, and negativity towards the change in shift reporting procedures. A pre-implementation staff survey was conducted to evaluate the knowledge, attitudes, and comfort levels of the nurses using the BSR (See Appendix A). Utilizing the unit manager and facility educators ensures that BSR will be part of the unit's nursing quality improvement initiative. The aim of this project is to develop a change in practice by moving the shift report from the nurses' station to the patient's bedside.

Problem Description

The current process of end-of-shift report at the nurses' station lacks consistency and structure and occurs away from the patient's bedside, increasing the risk of potential harm to the patient (Ofori-Atta, Binieda, & Chalupka, 2015). Notably, ineffective communication during shift-to-shift reports can contribute to gaps in patient care and breaches in patient safety, including medication errors, falls and sentinel events. During a patient's stay in the hospital, they are frequently transferred and cared for by different healthcare providers. Primary care nurses receive handoffs daily across various settings from other units when a new shift assumes care of a patient or when there is a change in a nursing assignment during a shift. The nurses spend the first 30–45 minutes of each shift away from their patient, which results in them being "left alone" for an extended period. Research has shown that sentinel events are more likely to occur during this "alone" time (Ofori-Atta et al., 2015). Relocating nursing shift handoffs to the patient's bedside will eliminate that alone time. Most importantly, it will allow both the outgoing and incoming nurses assess the patient's current status and compare their assessment to eliminate any inconsistency or misunderstanding in the transfer of knowledge and examine for any patient safety errors. The BSR also allows the patient to be involved of their plan of care and build trust and partnerships with the patient and family.

During random staff interviews, many nurses voiced their frustrations because the report they received did not align with the patient's condition. There has been evidence of the incoming nurse finding the IV site infiltrated, wrong primary IV fluid infused, disconnected oxygen, tube feeding dislodged from the percutaneous endoscopic gastrostomy (PEG) site, colostomy bag disconnected, or even the patient found in distress. All of these finding were discovered after the reports are completed, the on-coming nurse has arrived at the bedside and the outgoing nurse has left the unit. These findings cause conflict among nurses because of the inconsistency in the report and the delay in care to other patients, which put patient's safety at risk. In addition, nurses are frustrated because getting behind with other tasks; often, they would have to stay over to finish their work and documentation. Effective communication is the key to the safety and wellbeing of a patient. Patient safety checks should be integrated into the change-of-shift process.

Major benefits of implementing BSR are providing patient-centered care by allowing patients and family members to participate in their care, opening the line of communication, improving the patient care experience, allowing more of a patient's individualized needs to be met, and better outcomes hence improved patient satisfaction (Vines, Dupler, Van Son, & Guido, 2014). Other benefits of BSR are improvement in communication by the use of SBAR, a standardized handoff tool (situation, background, assessment, recommendation). The use of this handoff tool has been shown to eliminate any gaps in the exchange of relevant information, a decrease of insufficient or misleading information, a decrease of incidental overtime, and a decrease in healthcare expenditures (See Appendix B). According to a study conducted by Agency for Healthcare Research and Quality (AHRQ), nearly 53% of healthcare professionals state that relevant information is lost during handoff reporting (Bigani & Correia, 2018). Without

a standardized reporting tool, vital information can be omitted. Ineffective communication has been related to delays in care, readmission, and adverse events. Healthcare organizations are no longer reimbursed for the services of these preventable errors. These incidents cost institutions billions of dollars every year (Bigani & Correia, 2018). Therefore, the transfer of information must be complete, concise, accurate, and consistent (Vines et al., 2014).

Communication breakdown can contribute to gaps in patient care and increase the risks to patient safety. One reason for this is everyone has different communication styles, skills, and experiences, which can cause inconsistencies. Some nurses focus on a detailed description of the patient's situation, using the "big picture" with a broad narrative while some are solely focused on critical information (Friesen, White, & Byers, 2008). Another gap in communication is a variation in processes because nurses work in different settings and have different views about what information is critical to convey during handoff communication. Variation in handoff has been shown to lead information gaps, the omission of critical information, and contribute to error in patient care, thereby creating poor patient outcomes (Mitchell, Gudeczauskas, Therrien, & Zauher, 2018). Often, nurses complain that the handoff report is disorganized and inconsistent, leading them to ask for clarification, which can lead to overtime in the handover report.

Available Knowledge

PICOT Questions

A PICO statement used in the literature search was developed to improve handoff communication in the microsystem. The PICO (population, intervention, comparison, outcome) was as follows: (P), adults in the intensive care unit (ICU), (I), relocate handoff reporting at the

bedside (C), traditional shift report at the nurses' station, (O) improves patient and nurse satisfaction and reduction of communication errors, (T) over a six months' timeframe.

PICOT Questions: For adult patients in the ICU setting, does bedside reporting increase patient and nurse satisfaction compared to reporting at the nurses' station?

Literature Search

A literature review was conducted to gather the most up-to-date, relevant, and evidence-based practice articles to support this project's aim of using standardized bedside shift reports to improve nurse communication and patient safety. The literature search utilized several databases: CINAHL, Pub Med, and Fusion. The keywords searched included: *Bedside shift report, quality improvement, medical errors, patient safety, improve satisfaction, improve communication.* The articles selected were limited to English only and articles published between 2008-2020. The five identified articles were reviewed as an annotated bibliography (See Appendix C). The literature review utilized for this project on the concept of bedside shift report guided the implementation of evidence-based practices to significantly improve communication and patient safety. The authors find that bedside reports not only promoted patient safety, but there is also an increased accountability and transparency when everyone is involved in the handover report. The articles are relevant to the research topic because they offer credible information and theories from trusted sources.

Rationale

The change theory selected to implement patient handoff communication is Kotter's 8-step Process for Leading Change. This change model focuses on improving a company's capability to change as well as increasing its chance of success. This model was selected because it provides

an efficient way to create a vision of change and convince nurses, especially those who are resistant to changing behaviors, of the reason behind the change.

Kotter's 8-step Process for Leading Change model consists of eight components for organizational change: "(1) create a sense of urgency; (2) create a guiding coalition; (3) create a vision of change; (4) communicate the vision; (5) remove obstacles; (6) create a short-term win; (7) consolidate improvements; (8) anchor the changes" (Mulder, 2012). This change model can convince nurses of the importance of the new process. The clinical nurse leader (CNL) must make her subordinates understand why the change is necessary and inspire them to move to more efficient methods of bedside nurse-to-nurse handoffs. For change to happen, a consensus between the management and CNL is required. Many nurses worry about change, so it is important to prepare the staff physically and emotionally for the process and guide them to overcome those obstacles. Give staff a chance to have their fears and concerns heard, and seek feedback. Kotter's process can also help reveal what is working well and what is not working and find ways to improve and overcome the barriers.

In the microsystem in which this change strategy will be implemented, there is need for bedside handoff communication interventions. Without standardized guidelines for bedside patient handoff, there is increased risk of medical errors, communication breakdowns, and patient safety issues. Based on Kotter's 8-step Process for Leading Change model, CNLs will be able to evaluate the inconsistencies in handoff reporting, analyze the barriers, and help guide staff members to overcome their fears. Communication, proper planning, and listening to staff concerns can all help ensure a standardized bedside shift report is implemented. While it is true that many nurses are accustomed to their habits and that change is difficult and can be a slow process, the fact is that continued staff education, support, and guidance will make it possible for

nurses to comply with the new bedside report practice and participate in the new process of reporting.

Specific Project Aim

The aim of this project is to implement and sustain the process of standardized bedside reports at medical-surgical ICU to achieve 80% nurse compliance and demonstrate quality and effective bedside reports at shift change by a projected date of August 2020. The goal of the project is to improve patient safety through enhanced communication and to improve both patient and staff satisfaction.

Methodology

Context

The initial step of the improvement project is to identify a need for change. A microsystem assessment was conducted using the Dartmouth Microsystem Assessment tool to guide and promote the concept of bedside shift report. Upon completion of a microsystem assessment of the medical-surgical ICU at SLRH utilizing the 5 P's (Purpose, Patients, Professional, Process, and Patterns). A SWOT analysis was completed to identify the strengths, weakness, opportunities, and threats to assess the readiness of implementing BSR. In addition, a root cause analysis and a fishbone diagram were utilized to determine the causes of ineffective communication during shift reports. The overall aim of this project is to improve communication and collaboration among nurses to ensure patient safety and improve quality and effective patient care.

Microsystem Assessment

After noticing the nurses' frustration over inconsistencies in the information being transferred during shift handoffs and sentinel events are attributed to communication failure

between healthcare providers, it was apparent to address the microsystem's improvement need for quality and safety. Relocation of nursing end-of-shift handoffs to the patient's bedside will be part of the microsystem's quality improvement initiative. The microsystem setting where the change strategy will be implemented is an eight-bed, medical-surgical ICU that focuses on comprehensive, continuous care for patients who require around-the-clock, intensive monitoring and invasive treatments. The medical staff is comprised of intensivists, cardiologists, nephrologists, gastroenterologists, neurologists, and surgeons. The ICU staff consists of one unit manager, forty registered nurses including traveler nurses, and per diems who work a mix of eight- or twelve-hour shifts. The interdisciplinary support staff includes a pharmacist, respiratory therapist, nutritionist, physical therapist, occupational therapist, speech therapist, social worker, case manager, and educator. The Top Ten diagnoses and conditions include myocardial infarction, acute respiratory failure, stroke, diabetic ketoacidosis, GI bleed, severe sepsis, drug overdose, alcohol withdrawal, renal failure, post-op complicated surgery, and major or minor trauma. The key stakeholders in the system are the clinical staff members, who provide the first line of inpatient care, nursing management, facility educators, the patient, and the patient's family.

The clinical nurse leader's functions within the microsystem are to improve the delivery of patient care and to improve patient outcomes. According to the American Association of College of Nursing (2013), the CNL "assumes accountability for the 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). Therefore, to make a sustained change at the level of the microsystem, it is necessary to improve effective handoff communication between healthcare providers. This sustained change will occur through proper

education on handoff communication and adapting to the evidence-based practice standardized of the bedside shift report.

Prior to implementing this project, the initial step is to have a conversation with the unit manager and facility educator. Next, the involved parties need to agree that BSR will be part of the unit's nursing quality improvement initiative. Then, we will focus on utilizing the Institute of Healthcare Improvement (IHI) model for accelerating improvements and determining the desired outcomes. Lastly, it will be determined whether the changes are leading to improvement. A SWOT (strengths, weaknesses, opportunities, and threats) analysis was created to determine the feasibility of implementing BSR in the intensive care unit (See Appendix D). In addition, a root cause analysis was conducted in order to determine the possible causes of ineffective communication and noncompliance of nurses with shift handoffs report (See Appendix E).

Cost-Benefit Analysis

The projected costs for executing the project include a formal one-hour introductory education and in-service training for nurses on effective communication and the use of a standardized handoff tool. At this institution, a registered nurse receives an hourly rate of $79.15/hour (SCVMC, 2019). The ICU staff consists of a total 40 registered nurses in the unit; therefore, the estimated cost for education and training would be $3,116. Also, materials will need to be printed to produce the template of the handover report. Their estimated costs, along with the supplies for the PowerPoint presentation, template report tools, and toner, are $550 for one year. At SLRH, the turnover time to train ten newly hired nurses is about 60 hours, so the orientation, computer training, and unit orientation per nurse are estimated to cost $47,490 per year (See Appendix F).

According to Choi et al. (2016), treatment cost attributable to a single incident of medication error even without patient harm is an estimated $8,439. Incidental overtime and medication error create a financial burden for the hospital. If prevented, SLRH can save as much as $166,545 per year. Therefore, the implementation of the BSR Cost-Benefit Ratio generates $45.82 for every $1.00 in cost (See Appendix F).

Bedside shift report is a major contributor to reducing overtime accumulated between shift changes and financial savings. The BSR is more time efficient than having the shift handoffs conducted at the nurses' station. When handover occurs at the bedside, nurses spend less time socializing among themselves, which can lead to nurses leaving on time, reducing incidental overtime, and allowing direct patient care to begin sooner for the oncoming nurse. The literature review by Dorvil (2018) shows that after the implementation of bedside shift report, the nursing overtime decreased by ten minutes per day and resulted in a decrease in annual salary expenses ranging from $95,680 for overtime paid at the regular hourly rate to $143,520 for overtime paid at the time-and-a-half rate. Dorvil (2018) also reported a decrease in incidental overtime by 100 hours during the first month of bedside shift report implementation (Dorvil, 2018).

An analysis of the costs and benefits of the business plan must be done to determine whether the use of bedside shift report is cost effective for the SLRH ICU department. BSR has many benefits, as it has been proven to improve patient safety through a decrease sentinel events, medication errors, and patient falls and other hospital-acquired conditions; it also decreases paid overtime, length of stay, and costs to healthcare facilities, all of which could affect hospital reimbursement.

Unplanned incidental overtime for the SLRH ICU for 2019 was 963 hours. Based on a literature review by Dorvil (2018) using the SBAR tool and after implementation of a nurse bedside shift report project, a nursing overtime decrease of ten minutes per day can be achieved. It is assumed the same would apply to SLRH; a decrease in overtime of ten minutes would result in savings of $7,223 per year for overtime paid at the time-and-a-half rate of $118.73 per hour (See Appendix G).

Overall, the benefits of BSR are improved patient safety and patient-centered care, decreased anxiety and increased trust with the patient and family, improved nurse communication, encouraged teamwork and accountability, and reduced falls and medication errors. Furthermore, not only does BSR improve patient safety, but it also improves Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) patient satisfaction scores, which are crucial to hospital reimbursement. Also, the BSR standardized handoff tool decreases nurse-to-nurse report time, resulting in less paid overtime. A literature review showed that at one 34-bed progressive care unit, using an SBAR tool decreased the report time from approximately 40 minutes to 10 minutes. The institution saved $8,000 in two months due to the reduction in overtime (Ofori-Atta et al., 2015).

Intervention

This project involved collaboration between the manager and nurses to change the policy, which encompasses the use of standardized handoff tools to be implemented along with bedside shift reports for all patient handoffs. Notably, changes that are instigated at the upper levels have the capability of causing and sustaining change in the lower levels of the organization more effectively. In the case of the St. Louise Regional Hospital, it is unarguable that hospital leaders

seek to intensify their efforts in transforming the environment to guarantee patient satisfaction, patient safety, and nurse contentment.

From the hospital leaders, the implementation of the intervention trickles down to nursing leaders. These are in charge of implementing practice changes and monitoring the performance of nurses. For example, their role in overseeing practices such as relocating the locations of the shift reports from desks to the bedsides is indispensable. Finally, the interventions also include a pre-implementation nurse satisfaction survey, PowerPoint presentation, interviews, and practice scenarios. For example, a role-play huddle will be demonstrated to display effective communication during the bedside report process. Following the presentation, a written post-test will be given to check the knowledge of the information presented (See Appendix H). A daily huddle at change-of-shift will occur to remind and reinforce BSR. A post-implementation nurse satisfaction survey will be conducted in six months to address any concerns (See Appendix I). Another intervention to streamline bedside handoffs is using a report checklist (See Appendix J). At the end-of-shift change, nurses will conduct BSR using the checklist to ensure they cover the key elements, and this information will assist the nurse in planning and prioritizing care based on the patients' acuity. The checklist can be posted on the work station on wheels (WOW) as a reminder of what to cover during bedside shift handoffs. In addition, allowing the patient and family to be involved in nurse BSR gives them the opportunity to hear the plan of care, ask questions, and provide input in the care process. Patient and family engagement creates an environment of cohesiveness to improve the quality and safety of hospital care.

The project began in January 2020, with the goal end date of August 2020. This is depicted in the Gantt chart (See Appendix K). The chart reflects the timeline used during the bedside shift report improvement project. With the goal end date of August 2020, the specific objective for

this project is to improve nurse communication during bedside handoff by at least 80% to enhance patient satisfaction, promote patient safety, and improve patient outcomes. During the COVID-19 pandemic, practicing BSR is on hold. Once the COVID-19 pandemic tapers and family member are permitted to visit, the bedside nursing handoff process will be an on-going microsystem reassessment to advocate continuing BSR and support the team members in facilitating transitions of care and safe handoff.

Active patient involvement in the process of handoff is a critical part of the intervention strategy as well. This is the final part of the hierarchy, which the nurses engage the patients. The outgoing nurse offers the oncoming nurse the opportunity to check and verify the probable drug reactions, pump settings, and medications. This implementation of change facilitates a two-verifier system. In addition, the oncoming nurse checks the overall appearance of the patient and records the essential measurements, such as blood pressure. A handoff that exhibits these attributes facilitates communication between the patient and the oncoming nurse and also guarantees the accountability of the nurse. In the long run, the multiple short-term goals that the patient and the nurses create and achieve together expedite the long-term goal.

Study of the Interventions

Measurement Strategy

On the day of admission, the primary nurse briefly explains the process of the bedside shift report. During shift change, nurses are required to successfully transfer information between nurses to prevent adverse events and medical errors. The process is measured by the direct observation of nurses during BSR to calculate how often bedside handoff is being done, a review of risk management reports observing the number and severity of medication errors, and a decrease in overtime due to more efficient shift-to-shift bedside reports.

The PDSA (Plan-Do-Study-Act) cycle developed by Dr. W. Edward Deming is a framework for the quality improvement strategy (See Appendix L). The PDSA cycle provides an effective approach for problem-solving, assessing results, and managing change (Finkelman, 2016). PDSA was conducted to evaluate the effectiveness of communication problems with shift handoff improvement projects. In the PDSA planning phase, the CNL identified the current situation of shift-to-shift handoff among nurses and analyzed the problem. The first step to measuring the success of the new handoff communication is to collect patient satisfaction surveys regarding nurse-patient interaction. Next, obtain employees' survey input on why change is necessary and explore how the change benefits them. In the Do phase, analyze the progress if the change was effective, identify what did not work, and make changes if necessary to achieve the goal. The CNL maintains open communication with the staff during the change process to reduce resistance and help them feel like part of the change team. In the Study phase, the before-and-after results are compared based on current data and measure of effectiveness. The CNL can obtain the nurses' input to see if they recognize the difference in their care and can prioritize their duties more efficiently as a result of decreasing preventable complications in patient care. Last, in the Act phase, document if the bedside handoff report was successful. Give employees the power to implement change at their own level and allow time for the change to be embedded in daily practice (Skhmot, 2017).

Measures

The goals of this project are to change the handoff strategy in nursing practice and to standardize the process of nurse bedside shift reports. The aim is to increase the nurses' compliance with BSR in the ICU to 80% within six months of implementation. The outcome measure was identified by a pre-implementation staff survey that evaluated the emotions,

attitudes, and perceptions of bedside handoffs. The survey consisted of questions that asked the nurses how often they practiced bedside reporting. The pre-implementation survey revealed that out of 40 nurses, 15% of nurses answered, "most of the time," 37.5%, "sometimes," and 47.5%, "never." In addition, the survey asked if a bedside shift report checklist would improve their workflow. Less than half of participants, 37.5%, responded yes, and the majority of the respondents, 62.5%, said no (See Appendix M).

The process of implementing nurse BSR involves taking part in evaluating the nurses' compliance by modeling behavior, practicing skills, and observing the nurses' bedside shift reports. The sustainability of this project requires ongoing periodical observations at two weeks, two months, and four months after the start date to ensure the bedside report format is implemented consistently, provides feedback, and constantly rounds on nurses at shift changes to make sure behaviors become routine. The balancing measures include education and implementation processes, observations of improvement on various aspects such as improved communication between nurses, enhancement of workflow, ability to plan and prioritize work, increase of efficiency on reports, and decrease of the duration of reports.

Ethical Considerations

The project was reviewed and approved by the faculty as a quality improvement initiative project by evidence-based practice literature rather than a research project. The literature review articles on nurse bedside shifts report the successful implementation and sustainability of bedside shift reports.

In any healthcare setting, irrespective of the workplace, nurses face ethical dilemmas or moral stress on a daily basis. Nurses make ethical decisions that can significantly impact them and their patients. According to the ethics code of the American Nurses Association, nurses have

ethical and professional obligations to advocate for their patients' optimum health as well as provide safe, efficient, and compassionate care. The most important values of a nurse are beneficence, nonmaleficence, and respect for autonomy. Beneficence simply means "to do good," for instance, to lift the side rails on a patient's hospital bed to prevent falls. Nonmaleficence, which means "doing no harm," in this situation, relates to identifying medication errors and immediately correcting them to minimize any possible harm to the patient. The last principle is autonomy, or "right to self-determination." Patients have the right to make decisions about their own care. Nursing ethical practice includes respecting and recognizing an individual's right to make decisions even if the nurse does not agree with the patient's decision. In this situation, refusing care is part of the patient's right to autonomy. However, there are circumstances where nurses have to follow institution policies in the best interest of the patients. Nurses have an ethical and professional duty to do the most beneficial things to help patients. The four aims of the Institute of Healthcare Improvement (IHI) focus on improving the health of populations, enhancing patient experience, reducing healthcare costs, and making the work lives of healthcare providers enjoyable. Safety is always the primary concern in nursing.

Outcome Measure Results

Standardizing the bedside shift report process is an effective approach to improving communication, teamwork, and collaboration among nurses. By improving the effectiveness of communication among nurses in the unit, this project is expected to yield the following results: improved safety and quality of care, improved patient outcomes, increased patient and nursing satisfaction and decrease overtime related to shift report. In addition, a bedside shift report checklist will include necessary information to ensure continuity of care, improved patient and family engagement, reduction of errors and near misses, and reduced shift report times to

maintain the unit budget. It is anticipated that at least 80% of the nurses will comply with this new bedside shift report practice in the ICU within six months of implementation. It is anticipated that the use of SBAR and the BSR checklist will offer a consistent, standardized communication format for nurses and improved clarity for the organization of information.

A standardized communication format will facilitate positive delivery of patient care and the prevention of adverse outcomes. With the cooperation and dedication of management and staff, it is possible to implement this project successfully. However, there was pushback on a quality-improvement measure, and valid data related to shift reporting post-implementation was unavailable due to the COVID-19 pandemic. The effects of coronavirus pandemic of nursing handoff interventions were limited in measuring the patient and nurse satisfaction and relationship improvement among nurses and patients, as well as the strategies for effective nursing handoff because of the isolation protocol, limited staff exposure, and used of the personal protective equipment (PPE). The outbreak of COVID-19 has caused a strain on nursing practices and activities linked to health facilities, particularly when the procedure in the context requires communication. For example, for nurses in ICU bedsides, their routines have changed drastically, as they are required to offer all care in one single batch, be careful about what they touch around the room and in the surrounding area, wash hands frequently, and communicate with others outside using motion and gestures. Unarguably, the strain extends to the evaluation of the effectiveness of the project because of the exposure risk. The nurses and the patients are all skeptical about interacting with each other because of the setting. While it is easy to get the quality-improvement measure through semi-structured, telephone interviews, the method only works for one group of participants, the nurses. Thus, it remains challenging to obtain an accurate measure of the success of the project, because involving the patients would be grim.

Discussion

Summary

The handoff report is an integral part of a nurse's daily routine. Performing a BSR is beneficial for the patient and the nurse. BSR also enhances patient safety by improving the quality, accuracy and effectiveness of the report. In the critical care unit where patients have multiple health problems, a complete shift handover report is crucial, in addition to the overall complexity and the tremendous amount of information that is exchanged between nurses. This project's goal was to initiate a standardized approach to shift reports to improve nursing communication, ensure safe transference of responsibility and accountability between clinicians, facilitate a clear transition of patient care, and promote patient-centered care by providing patients with information about their care plan. The project's specific aim is to increase nurses' compliance with transitioning to bedside reporting on the intensive care unit to at least 80% by August 2020.

The current process of end-of-shift reports at the nurses' station shows a lack of consistency, formal structure, and guidelines, which can lead to ineffectiveness and inadequate sharing of pertinent information during shift changes. The primary motivator for this project was revealed by observations, interviews, and the pre-implementation nurse survey. The survey consisted of questions to determine nurse attitudes on bedside shift reports. Of the 40 surveyed, 37.5% of nurses said they "sometimes" practice bedside reporting, while 47.5% said they "never" practice bedside reporting. In addition, the survey asked if a bedside shift report checklist would improve their workflow. Less than half of participants, 37.5%, responded yes, and the majority of the respondents, 62.5%, said no. Furthermore, nurses voiced their dissatisfaction with the inconsistent information they receive about their patients, which often does not match the patients' current conditions. At times, the physicians get frustrated because the oncoming nurses

do not know vital information. The nurses answer the physicians by saying, "I didn't get that in report." This puts the nurse on the spot, for he or she did not receive adequate information from the outgoing nurse; however, nurses need such information to care for their patients effectively. In addition, the shifts report often last longer than 30 minutes, which can cause the oncoming nurse to get behind at the beginning of the shift. It may take the entire shift to get caught up, which can result in staff overtime.

At the initial educational in-service, nurses often do not realize the importance and benefits of BSRs. The nurses may not put their best efforts into implementing BSR because they believe it burdens their workflow. One way to reverse their attitude and change this perception is to re-educate the staff on the advantages and disadvantages of bedside reporting and how it can be beneficial. Staff can have open discussions about the numerous studies on evidence-based practices that support the efficacy of bedside shift reports in relation to patient safety and quality care. Examples should be provided to show how bedside shift reports can prevent mishaps and medication errors and reduce falls during shift changes. Proper training and education would result in patients' positive outcomes and overall satisfaction.

The microsystem assessment was initiated in early January 2020, and the project was scheduled to start in early March 2020, but due to the COVID-19 pandemic and a conflict with internship schedules, the implementation of BSRs is on hold. The unit continues to have COVID-19 patients, and no family members are allowed to visit. This is a major barrier to BSR implementation and led the nurses not to use BSRs. Although there is no official data analysis or evaluation, there are numerous literature studies have shown that after implementation of the standardized report guidelines or template in the handoff process, the incidence of nursing errors or adverse event were reduced dramatically. One review found bedside reporting prevented

adverse events, including the initiation of rapid response when a patient's condition changed from the last time the patient was seen during report (Mitchell et al., 2018).

The materials presented to the management resulted in buy-in to continue the project. I was asked to teach and reinforce the best practices in bedside shift reporting during our annual quality improvement competency skills class, with additional education in-service. There is hope that this project will be successful because of the support and interest of the unit manager and educational coordinator. It is projected that there will be an increase in nurse compliance, accountability, patient engagement, and patient satisfaction and a reduction in adverse events during shift changes and the cost of care delivery. Standardized training on how to conduct shift handoff, educating the nurses on the positive results of bedside reports, and monitoring the process will promote sustainability

Sustainability Plan

Changing the old reporting process at the nurses' station while sustaining the new practice of nurse bedside reports comes with challenges. The major threats to successful implementation and sustainability include lack of guidelines, cynicism and pessimism, negative nursing feedback, lack of management and staff buy-in, lack of shared vision, and inconsistency of implementation of the new process. The concepts used for implementing and sustaining the nurse bedside shift reports follow Everett Rogers' five-step approach to the adoption of innovation: knowledge, persuasion, decision, implementation, and confirmation phases (Dorvil, 2018). The knowledge phase is when the leadership and nursing staff are introduced to bedside handoff by having an evidence-based practice teaching plan, providing education and formal training in BSR practice through scenarios, role-playing, and continuing education on annual competencies (See Appendix N). The persuasion phase is discussing the advantages and disadvantages of

bedside handoffs. The goal of this phase is to establish open communication between the management and nurses to evaluate their perceptions, attitudes, and emotions in order to adapt the new report process. The goal of the decision phase is to engage staff in the development and planning phase of the process, use a standardized report process, and establish realistic goals.

The implementation phase includes conducting staff meetings for identifying and modifying bedside handoffs based on nursing feedback, barriers, and evaluation. The final step in the adoption of nurse bedside shift reports is the confirmation phase, which includes ongoing assessments of nurses' perceptiveness, encouragement of feedback to modify the bedside report process to meet their needs, continuous monitoring, and reinforcement of practice of the bedside shift reporting. The adoption of nurse bedside shift reports takes time, and nurses' behavioral change occurs gradually as they decide to make this change and maintain the new behavior.

This project's sustainability relies on the nurse leader and unit manager continuing to provide nurses with ongoing education, mentorship, support, and positive reinforcement. The strategies for the sustainability of the bedside shift report implementation plan includes monitoring for consistent practices, periodically conducting unit huddles with the staff, periodic observation, leadership rounding, patient rounding, and monthly reviews along with quarterly and annual reviews to assess any problems and provide the opportunity to make corrections. Data will be collected to monitor patient satisfaction via surveys, and data on nurse compliance will analyze the improvement process on sustaining bedside reports. Another way to sustain this improvement project is to incorporate BSR as part of the new policy (See Appendix O); this way, the staff is required to adhere to the new bedside report process. However, if the process has not improved, then reinstate training and orientation until positive results occur, and BSR practice becomes an established habit.

According to numerous evidence-based literature articles, many risk factors are associated with an ineffective handoff method. The Joint Commission has estimated that 80% of serious medical errors attributed to miscommunication between caregivers during shift-to-shift report (Mitchell et al., 2018). It is crucial for change to occur in the way nurses practice and communicate with each other and their patients. Effective handoff communication is the key to the safety and wellbeing of a patient. With the proposed changes, BSR addresses all the safety hazards by reducing adverse events, such as medical errors, medical complication, patient falls at shift change, and sentinel events. BSR improves patient safety, enhances the quality of care, improves patients' experiences and involvement in their own care, improves patient and nurse satisfaction, decreases unnecessary healthcare expenditures, and saves time.

The CNL is instrumental in promoting this process change. The data collected through patient surveys, patient satisfaction scores, and post-implementation surveys and evaluation were limited at this time due to the COVID-19 pandemic.

Conclusion

According to the evidence-based literature review, implementation of BSR in a community hospital, such as SLRH, is feasible. Studies show that implementing a standardized approach to handoff communication results in improvement of patient safety, positive patient outcomes and satisfaction, and effective and consistent patient care. In addition, the data shows a significant decrease in paid overtime, decreased legal costs related to medical errors and an overall improvement of patient experience survey scores from HCAHPS. However, relocating the shift report from the nurses' station to the patient’s bedside can be a challenging task. It is necessary to get people to think and feel differently, so they change their behavior to support the change in this microsystem. People are often resistant to change, which can be a major obstacle

in implementing organizational change. However, the PDSA cycle and Kotter's 8-step change theory framework will facilitate the change and sustain its success. This CNL quality improvement project revealed that changing staff behavior and practices can be challenging. Still, as safety is such a tremendous concern, the CNL should be able to lead the process for improvement. The CNL can help overcome their fears through practice and proper training on handoff communication, eliminating barriers, using evaluations, and giving feedback during times of transition. The CNL internship project provided the opportunity to "facilitate practice change based on the best available evidence that results in quality, safety, and fiscally responsible outcomes" (AACN, 2013, p. 13). Moving forward, the standardized bedside shift report, utilization of SBAR tool, and the use of a report checklist will increase patient care flow, improve communication and the transfer of responsibility, which is aimed at improving the quality of care; and increase overall patient safety and patient outcomes.

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Appendix A

Standardizing Bedside Shift Report

Initial Staff Survey

1.) How many years of nursing experience do you have?

A) 0-5 years B) 6-10 years C) 11-15years D) greater than 15 years

2.) Which shift do you work?

A) 7a-7p B) 7p-7a

3.) How often do you practice bedside reporting? (SELECT ONE)

A) Always B) Most of the time C) Sometimes D) Never

4.) Do you typically review the patient's chart/documentation prior to giving/receiving report?

A) Yes B) No

5.) How satisfied are you with the quality of information you received during shift handoff?

A) Very satisfied B) Satisfied C) Dissatisfied

6.) Which barriers have you experience that impede giving/receiving report at bedside?

A) Frequent interruptions B) Noise C) Insufficient staffing D) Lack of time

7.) Do you believe that a standardized clinical handoff tool is helpful? (i.e. SBAR)

A) Yes B) No

8.) Do you believe that bedside shift report checklist will improve your workflow?

A) Yes B) No

9.) What benefits can you identify in performing bedside shift handoff report?

10.) Do you feel comfortable getting patient/families involved in bedside shift report?

Appendix B

SBAR / Change of shift report tool

	Report begins promptly 0700 and 1900 Report should take no more than 5 minutes Discuss any confidential information outside patients' room.
I **Introduce**	**Offgoing nurse:** Introduction and manage up of new nurse "Hello, I would like to introduce you to the nurse who will be continuing your care. His name is _____. He is an excellent nurse that has worked in ICU for # years. He received his nursing certification in Critical Care. **Oncoming nurse:** Introduce self. Check armband (name, date of birth, allergies, limb alert) Update the whiteboard
S **Situation**	**Main concern or situation** Pt name: _____ Age:_____ Room #:_____ Sex:_____ Physician:_____ Code Status:_____ Admitted from: _____ Level of care:_____
B **Background**	**Brief history** Admission diagnosis _____ Fall risk:_____ Pertinent past medical history _____ Restraints:_____ Date of Surgery (if applicable) Bed Alarm: _____ **On coming nurse:** Ask patient if they have any questions or concerns
A **Assessment**	**Review of the Systems** Current VS:_____ IVF:_____ Tubes/Drain:_____ IV sites/lines:_____ Neuro:_____ Cardio:_____ Rhythm:___ Pulse:_____ Edema:_____ Pulmonary: _____ O2:_____ GI/GU:_____ Diet:_____ Last BM:_____ Foley Catheter:_____ I&O:_____ Skin:_____ Wound/Incision:_____ Dressing:_____ Pain management:_____ Activity level:_____ **On coming nurse:** Do safety checks of patient condition and safety assessment of the environment Assess patient pain level
R **Recommendations**	**Suggestion of what need to be done** Validate any pending orders, plan of care, awaiting labs/procedures Discharge planning.

Appendix C

Annotated Bibliography

Bigani, D. K., & Correia, A. M. (2018). On the same page: Nurse, patient, and family perceptions of change-of-shift bedside report. *Journal of pediatric nursing*, *41*, 84–89 doi: 10.1016/j.pedn.2018.02.008

The authors of this article focus on exploring the nurse, patient, and family perceptions about change-of-shift bedside reports in the pediatric setting and describing specific safety concerns identified regarding change-of-shift handoffs. Bigani et al. (2018) reveal that bedside reports contribute to effective communication and increase patient safety. The authors detail how they created an exploratory-descriptive qualitative study tailored to elicit nurse, patient, and family experiences with change-of-shift bedside reports. The authors also relied on the use of interviews to identify common themes. Bigani et al. (2018) found that the results of their study were consistent with existing literature, showing that bedside reports contribute to effective communication and an increase in patient safety. The authors found that bedside reports promote patient safety and that there is increased accountability and transparency when everyone is involved in the handover of the report.

Clark, A., Wolgast, K. A., Mazur, N., & Mekis, A. (2020). Leading change in nurse bedside shift report. *Nursing Clinics, 55*(1), 21–28. doi: http:/dx.doi.org/10.1016/j.cnur.2019.10.002

According to Clark, Wolgast, Mazur, and Mekis (2020), the nurse bedside shift report (NBSR) involves two phases that help ensure the adaptability and sustainability of the change in practice. A pre- and post-survey proposes the implementation of a myriad of changes that

include the Innovative Incentive System (IIS). The ISS is developed by a project team and is tested and acts as an educational tool for the nurses. The educational toolkit resources were used to teach nurses about the bedside report and included a PowerPoint, video, practice scenario, and nurse champion education. From the survey generated from NBSR insights, they were proven to be reliable as they were subjected to a Likert scale. The medical-surgical care unit was instrumental in the formulation of the NBSR final report. There are proven indications that the NBSR has the capability to guarantee patient safety and patient involvement, strengthen communication with patients and staff, increase patient satisfaction scores, and reduce fall rates and overtime. According to the authors, the NBSR pilot's success and leadership support led to its acceptance by other inpatient unit nurses and buy-in from leadership.

Howard, K.P., & Becker, C.A. (2016). Moving change-of-shift report to the bedside for UAP. *Nursing 2016, 46*(4), 14–16. doi: 10.1097/01.NURSE.0000481434.79307.73

The authors intend for their research to illustrate the significance of moving shift reports to the bedside for unlicensed assistive personnel (UAP) within the healthcare setting. According to the authors, relocating the shift report is an evidence-based practice that enhances the overall patient experience, including patient satisfaction, nurse-patient interaction, and communication. The article highlights other positive effects on health care, such as patient safety, patient-centered care, teamwork, accountability, and effective communication. The authors used other studies from the Agency for Healthcare Research and Quality (AHRQ) to validate their claims that moving the shift report is necessary in the healthcare setting to improve the overall experience for both nurses and patients. The evidence the authors used indicates that a structured UAP bedside shift report as an evidence-based nursing practice improves UAP professionalism,

nurse-patient engagement, information sharing, and teamwork. The authors also provide a new process to train UAP using the SBART (situation, background, assessment, recommendation, and thank you) tool to focus on the patient's personal and safety needs. The changes observed in the new process, evidence from credible sources, and implementation processes all demonstrate that this source is valid, relevant, and informative.

Vines, M.M., Dupler, A.E., Van Son, C.R. & Guido, G. W. (2014). Improving client and nurse satisfaction through the utilization of bedside report. *Journal for Nurses in Professional Development, 30*(4), 166–173. doi: 10.1097/NND.0000000000000057

This article claimed that a bedside report is vital for patient safety, trust, nursing teamwork, and accountability; although, many nurses do not consider it best practice. The authors draw from the evidence in various literature to analyze whether a bedside report is a vital shift-handover practice for promoting both client and nurse satisfaction. The authors also evaluate various theoretical frameworks, such as Hildegard Peplau's model of interpersonal relations, as well as Kurt Lewin's theory of planned change, to illustrate the ability of bedside reporting to enhance positive outcomes for both patients and care providers. The findings show that a bedside shift report improves client satisfaction, as revealed in the HCAHPS survey report. The survey indicates a positive relationship and effective communication between patients and nurses. Also, the nursing satisfaction portion reveals positive views about bedside shift reports because these minimize communication errors, promote accountability, and enhance teamwork, collaboration, and respect. The authors recommend the application of Lewin's model of planned change to implement a bedside report effectively to facilitate patient-centered care as well as patient and

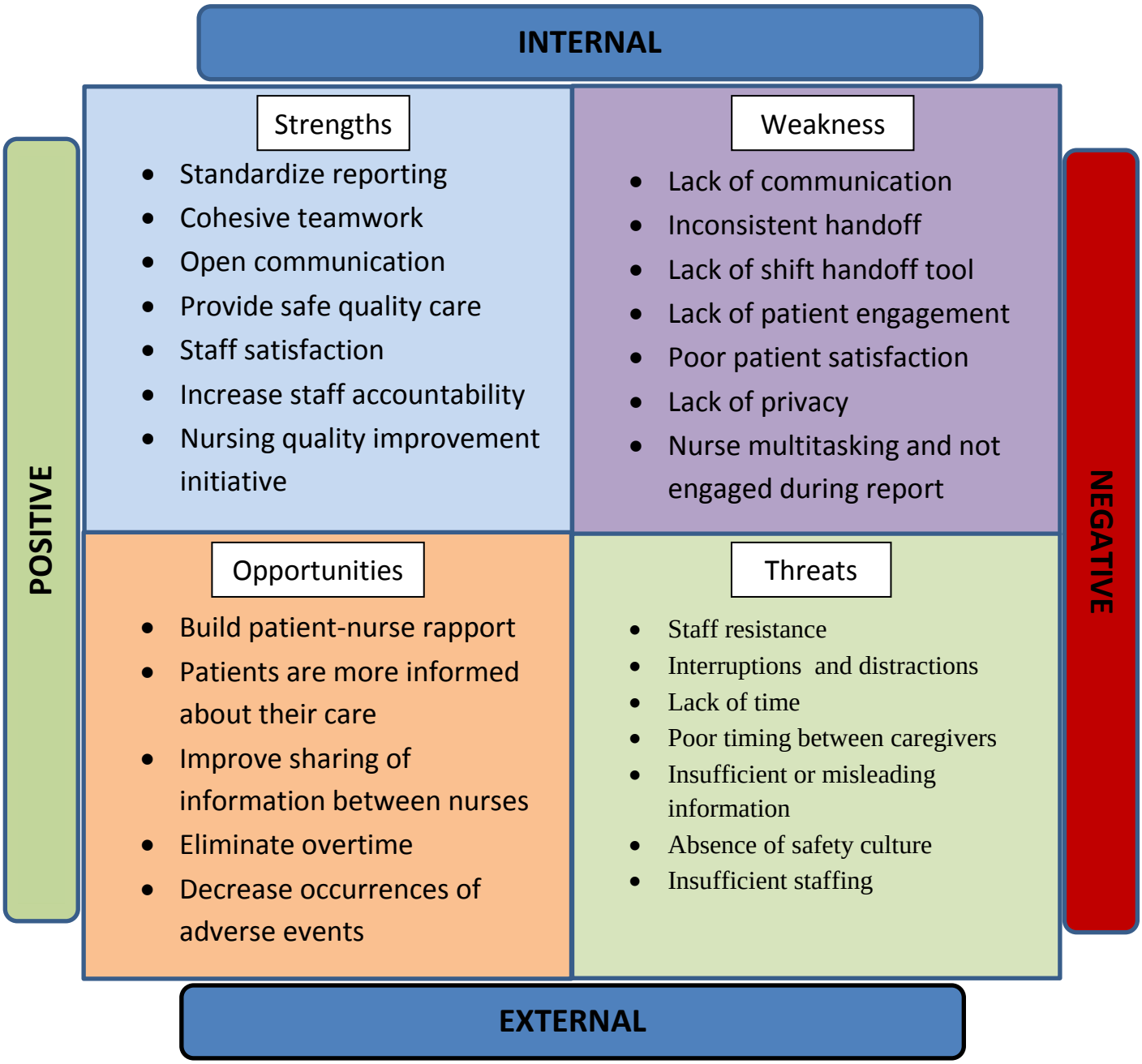
nurse satisfaction and to enhance communication. This article is relevant to the research topic because it offers credible information from trusted sources and theories.

Zou, X. J. & Zhang, Y. P. (2016). Rates of nursing errors and handoffs-related errors in a medical unit following implementation of a standardized nursing handoff form. *Journal of Nursing Care Quality, 31*(1), 61–67. doi: 10.1097/NCQ.0000000000000133

The article by Zou and Zhang shows an experiment to determine whether the standardized guideline and nursing handoff form or template can improve the effectiveness in the nursing handoff and reduce nursing errors. Some studies have shown that the nursing handoff process is incomplete, informal, and unstructured. A prospective intervention study, using an I-group quasi-experimental design, was done on an inpatient medical unit. The study involved all female participants with baccalaureate degrees in nursing and others with associate degrees. The experiment in the article was done on the 1963 admission preintervention period and 1970 admissions during the postintervention time. The analysis of the result, found by comparing the pre- and post-intervention periods, showed that the implementation of the nursing handoff form was effective in reducing overall nursing errors from 180 to 112. To achieve effectiveness in handoffs, clinical nurse leaders should devise nursing handoffs with guidelines and structures for patients and nurses.

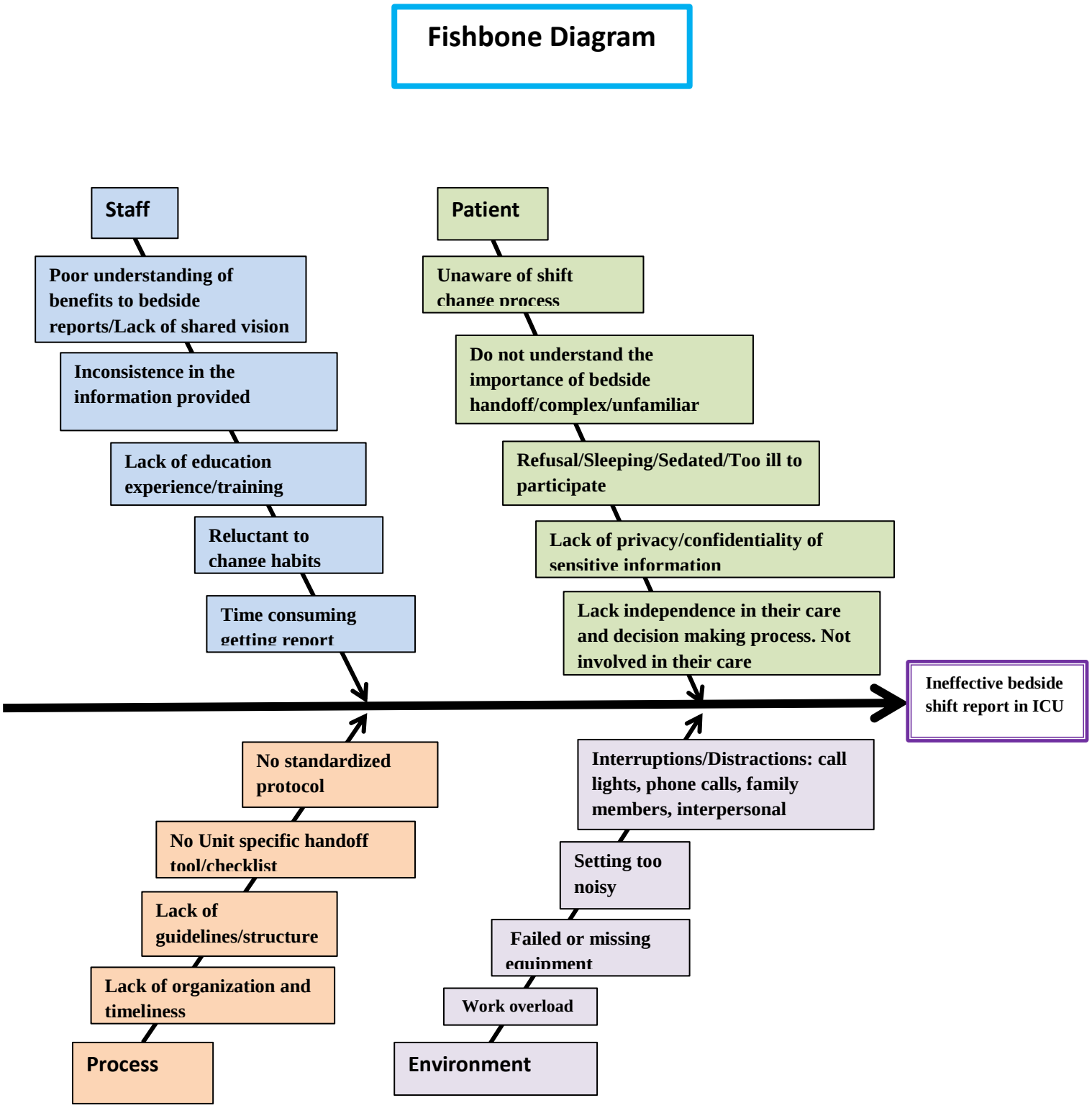
Appendix D

SWOT Analysis



Appendix E

Root Cause Analysis



Appendix F

Financial Analysis

Items	Cost
Nurses education and training (RN $79.15 / hour x 40 nurses x 1 hour training)	$3,166
Training materials	$550
Total cost BSR implementation	$3,716
Preventable Events	**Benefits**
Medication Errors	$8,439
Orientation of new seasoned staff members ($79.15 x 60 x 10)	$47,490
Nurse overtime per year ($79.15 x 963 x 1.5)	$114,332
Total Benefits	$170,261

Note: This table illustrates the total cost of BSR implementation and the potential savings from preventable events.

The net benefits = $170,261-$3,716=$166,545.

Benefits-cost ratio: BSR can generate $170,261 / $3,716=$45.82 for every $1.00 in cost

Appendix G

Cost Saving Analysis

Items	Cost
RN overtime per hour (RN Hourly Salary 79.15 x 1.5 OT)	$118.73
10 Minutes of OT per day (RN OT Salary $\frac{\$118.73 \times 10 \text{ minutes OT}}{60 \text{ minutes}}$)	$19.79
1 year of cost savings ($19.79 x 365 days)	$7,223

Appendix H

Educational Training Post Test

1. According to the Joint Commission, _____% of medical errors is attributed to ineffective communication.

a) 35%
b) 50%
c) 70%
d) 80%

2. How often should the shift handoff occur at the bedside?

a) Always
b) Most of the time
c) Sometimes
d) Never

3. According to National Patient Safety Goals established by The Joint Commission, bedside shift report found to employ which of the following?

a) Increases patient safety
b) Improves teamwork between care providers
c) Promotes transparency
d) Share responsibility for the patients' care
e) All of the above

4. In alignment with best nursing practice bedside shift report includes which of the following?

a) Introduction of new nurse
b) Update communication board
c) Integrate safety checks, IV sites, medication, pump setting, wound, dressing, etc.
d) Discuss plan of care and patient goals for the shift
e) All of the above

5. What are the benefits of bedside shift report?

a) Patient involved in their care are more satisfied
b) Prevent medical errors and adverse events
c) Shared accountability by both shifts
d) Oncoming nurse visualize patients and prioritize care for the shift
e) All of the above

Appendix I

Post Implementation Staff Survey

1. How often does the shift change handoff report occur at the bedside?

    a) Always

    b) Most of the time

    c) Sometimes

    d) Never

2. Do you believe that bedside shift report checklist will improve your workflow?

    a) Yes

    b) No

3. Since implementing the standardized clinical handoff tool, SBAR, do you see any improvement in workflow?

    a) Yes

    b) No

4. Do you feel comfortable getting patient/families involved in the bedside report?

    a) Yes

    b) No

5. How satisfied are you with the quality of information you received matches the patient's condition.

    a) Very satisfied

    b) Satisfied

    c) Dissatisfied

6. What barriers have you encounter that would impede you from performing bedside shift report?

7. Do you believe utilizing the SBAR had shortened your time performing beside shift report?

Appendix J

Bedside Shift Report Checklist

Introduction

- ☐ Off-going nurse introduces/manage up the on-coming nurse to the patient and family
- ☐ Invite the patient and family to take part in the bedside shift report
- ☐ Communicates utilizing AIDET (acknowledge, introduce, duration, explanation, thank you)
- ☐ Update the whiteboard (date, nurse, physicians, plan of care, etc.) use laymen's term

Information Exchange

- ☐ Conduct a verbal SBAR report (situation, background, assessment, and recommendation)
- ☐ Access the WOW (work station on wheels) during bedside report to review information
- ☐ Conduct a focused assessment of the patient
- ☐ Review tasks that need to be done (labs, medication, admission, consent, etc.)

Patient Engagement

- ☐ Identify if the patient has requested not to be disturb.
- ☐ Ask family/visitors to leave prior to information exchange unless patient has indicated otherwise to maintain HIPPA regulations.
- ☐ Discuss plan of care and patient's goal for the shift (use interpreter as needed)
- ☐ Identify the patient's needs or concerns (address the 4 P's, pain, position, potty, possessions)

Focused Safety Check

- ☐ Visually check patient's condition (IV sites, IV tubings, wounds, skin, drains, etc.)
- ☐ Conduct a safety assessment of the room for any physical safety concerns (bedrails, bed alarm, bed height, equipments)
- ☐ Move items within reach (table, call lights, phone, patient's belongings, etc.)
- ☐ Review electronic health record (EHR), MAR, vital signs, I & O's, new orders, etc.)

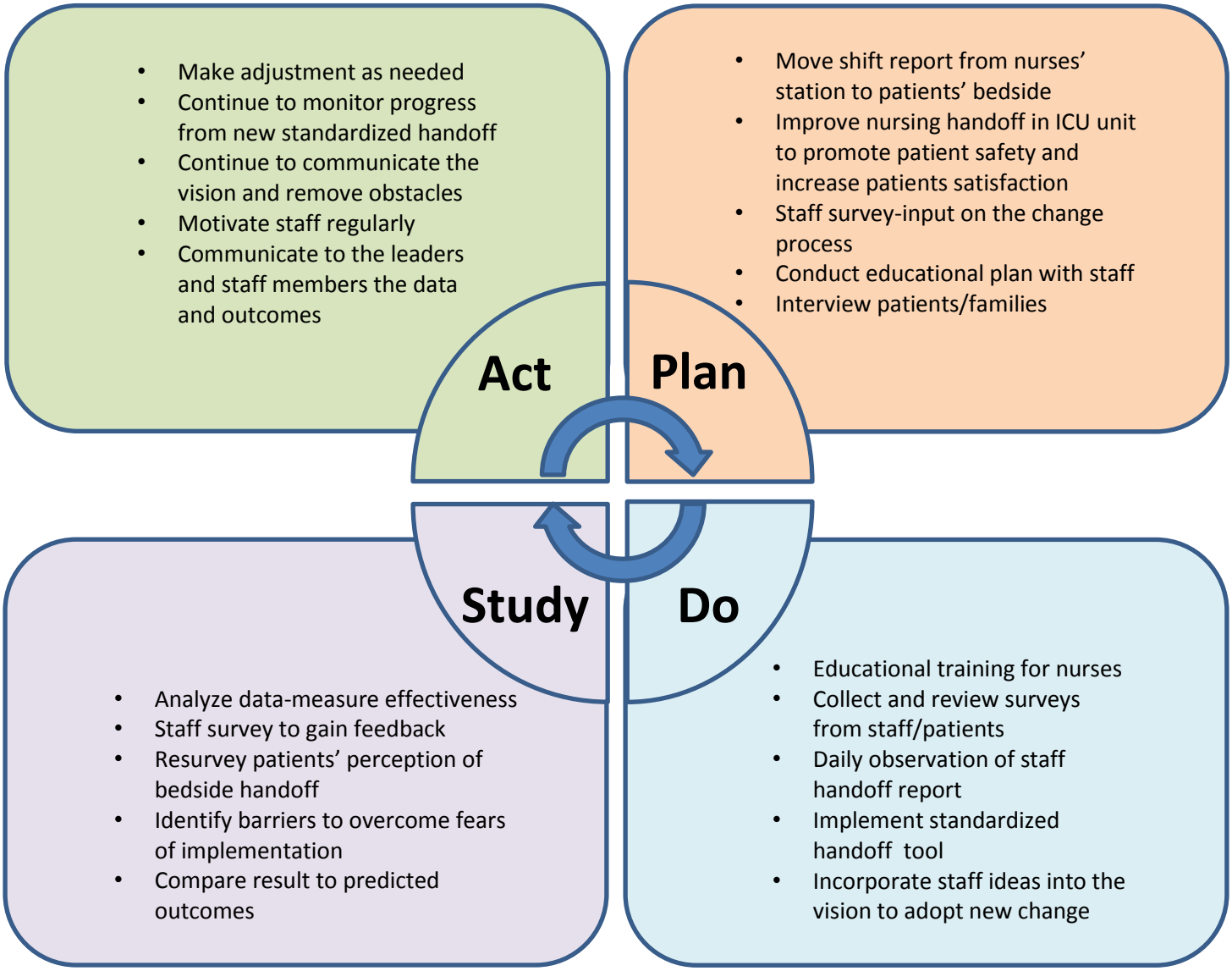
Appendix K

Gantt chart Project Timeline

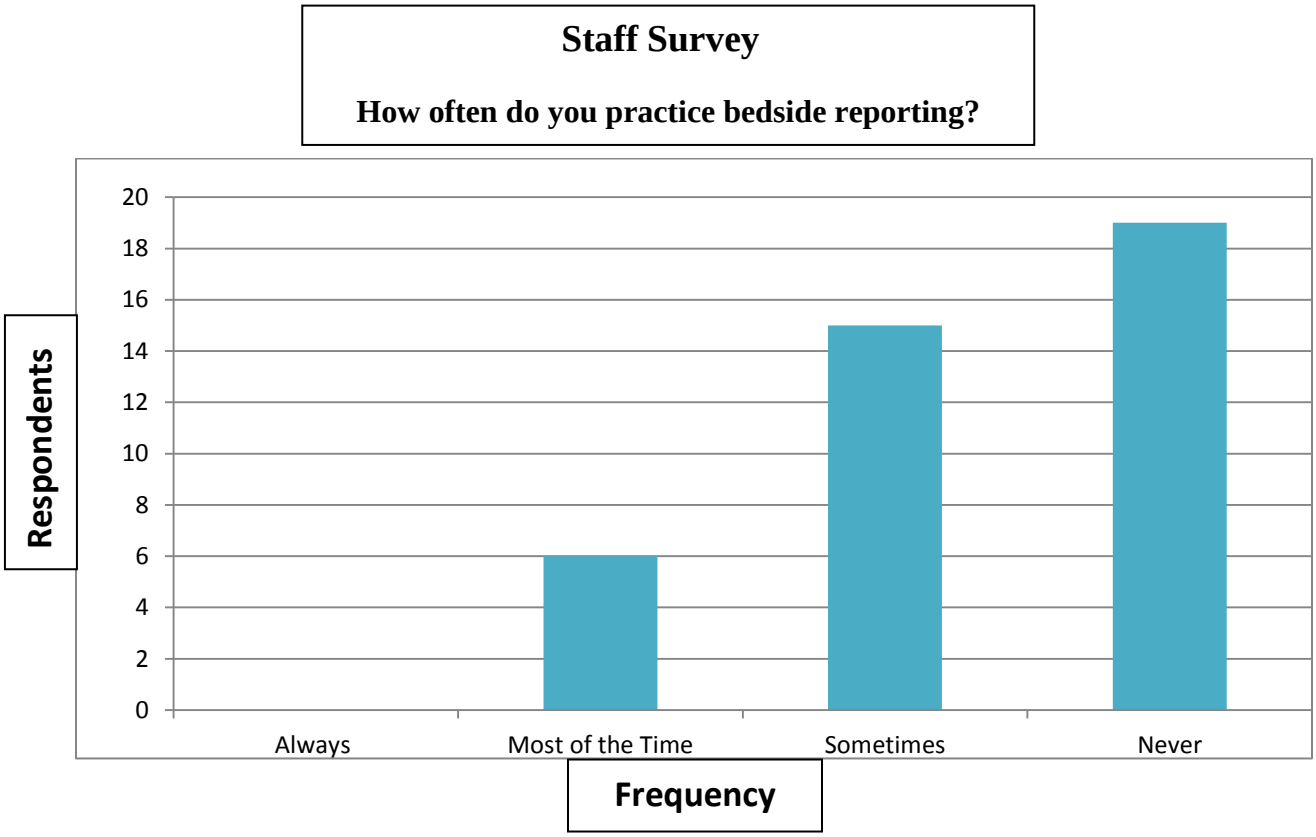
	Jan 2020	Feb 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020
Perform Microsystem Assessment								
Staff and Patient Survey								
Education session for staff on bedside report and handoff tool								
Go live on standardize handoff report								
Nurse Leader observation of bedside report and patient rounding								
Post implementation 3 months after Staff Survey								
Post implementation data analysis								

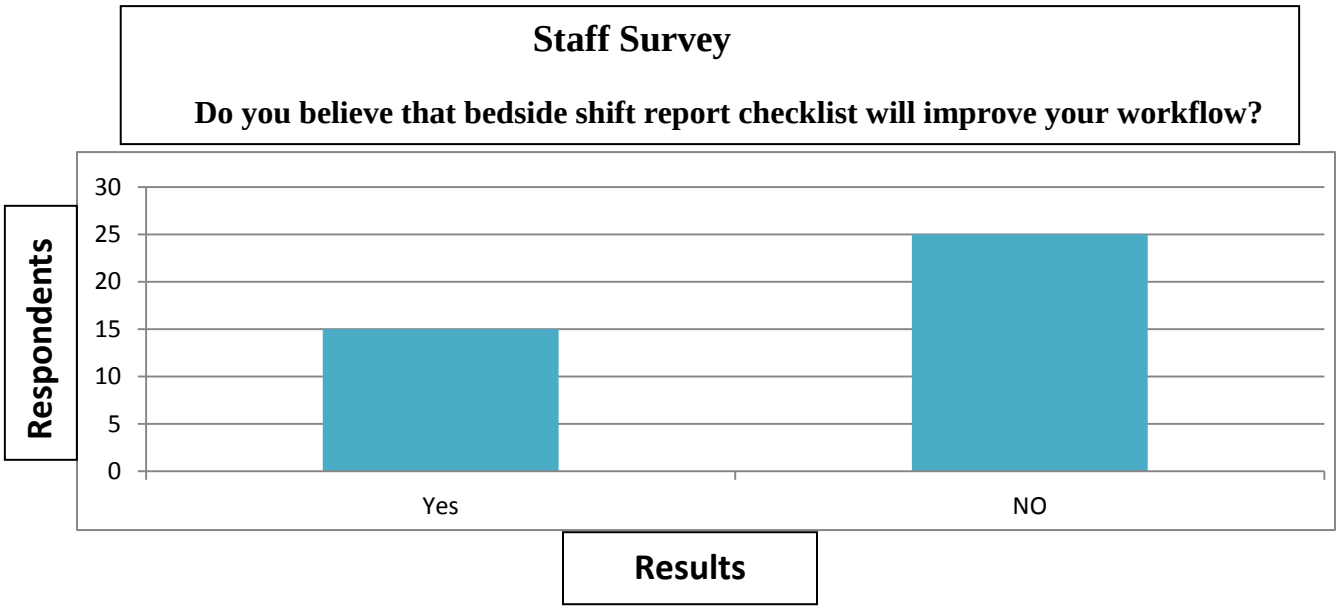
Appendix L

PDSA Cycle



Appendix M


Staff Survey
How often do you practice bedside reporting?
Respondents
20
18
16
14
12
10
8
6
4
2
0
Always
Most of the Time
Sometimes
Never
Frequency


Staff Survey
Do you believe that bedside shift report checklist will improve your workflow?
Respondents
30
25
20
15
10
5
0
Yes
NO
Results

Appendix N

Evidence-Based Teaching Plan

STEP 1 Literature review	Do microsystem assessments of current shift report practices, analyze the problems, identify the gaps, and formulate a plan to determine the best evidence-based practices for shift reports as compared to current practices. Conduct an evidence-based literature search on the best practices for conducting a bedside shift report.
STEP 2 Dialogue with the nursing staff	In the unit staff meeting and huddle, examine the nurses' perception of the bedside shift report. Educate the staff about the positive impact on the change process. Explain the benefits of the beside shift report. Listen to the nurses' fears and concerns about conducting the bedside shift report and acknowledge their voice in the change process.
STEP 3 Stakeholder to lead the change	The team consisting of the staff nurse, clinical nurse leader, unit manager, and educational coordinator assembled to review the evidence-based literature and make recommendations for changes that best meet the specific needs of the patients and the unit.
STEP 4 Surveys	Conduct a pre-implementation survey of staff members, patients, and family to evaluate the knowledge, attitudes, and comfort level with the bedside shift reports.
STEP 5 Staff education	Utilize various educational and training strategies such as PowerPoint slides presentation, modeling behavior, demonstration, and role playing providing feedback. A written post-test will be provided to check the knowledge of the information presented.
STEP 6 Process standardization	Standardized the critical elements of the bedside shift report by utilizing guidelines, SBAR format, and bedside shift report checklists to ensure a more uniform approach to end-of-shift communication and to present a consistent message.
STEP 7 Implementation assessment	Observe the bedside shift report process and provide positive feedback to individual nurses. Keep track of the observations, and collect and analyze data and outcome measures related to implementation.
STEP 8 Process refinement	Continue to conduct periodical observations to ensure implementation is consistent among the staff. Provide continual feedback and monitoring to make sure behavior becomes a habit and the bedside shift report is implemented consistently. Make adjustments as necessary.
STEP 9 Sustainability	An essential component of the unit's bedside shift report implementation plan is observation for consistent practice, leadership rounding, patient rounding, unit huddles with the staff to discuss any challenges and how to process could be improved, and quarterly and annual competency reviews.

Appendix O

Policy and Procedures for Bedside Shift Reports

Effective Date	August 2020
Applies to	All nursing staff in Intensive Care Unit
Review Date	August 2022

I. POLICY STATEMENT:

A. Effective and concise communication shall be provided during the transition from one caregiver to another to the patient's bedside.

B. Staff uses SBAR as a guideline when transferring patient care from one provider to another.

C. Collaborative communication is expected between St. Louise Regional Hospital (SLRH) employees, physicians, patients, and families.

D. Communication shall always comply with SLRH policies regarding the protection of patients' personal health records.

E. During handoff, the receiver must have an opportunity to ask and respond to questions.

F. AIDETS will be utilized to assist in the communication of necessary information when transferring the patient from one unit to another.

II. PURPOSE:

A. To ensure patient safety by providing a standardized process to transmit accurate, complete, and relevant patient vital information related to care, treatment, or services during handoffs from one caregiver to another.

III. DEFINITIONS:

A. Bedside handoff is described as the transfer of patient information, along with the authority and responsibility to care for that patient, from one health care provider to another during the transfer of care.

B. The bedside shift report (BSR) will be conducted by the off-going nurse and given to the on-coming nurse during shift change or transfer of care.

C. The bedside shift report is a standardized procedure to facilitate the successful transfer of information between nurses while engaging the patient and family members.

D. SBAR is a standardized communication strategy that promotes the effective transmission of information. SBAR is defined as:

- S = SITUATION: the main concern of the problem.
- B = BACKGROUND: pertinent and brief information related to the situation.
- A = ASSESSMENT: analysis of what is going on or what has happened.
- R = RECOMMENDATION: a suggestion or request of what needs to be done.

V. PROCEDURE:

A. The bedside shift report includes the following:

- Making patients aware of the BSR during the admission process.
- Introducing the nursing staff, patient, and family to one another.
- Inviting the patient and family member to participate.
- Communicating utilization of AIDETS.
- Opening the electronic health record at the bedside to review patient's information.
- Conducting a verbal report using SBAR in terms the patient and family can understand.
- Updating information regarding the patient's care, treatment, current condition, or any recent or anticipated changes in the patient.
- Conducting a focused assessment of the patient and the environment safety checks.
- Reviewing the task that still needs to be done.
- Identifying patient and family needs and concerns.
- Limiting interruption during the shift report to minimize the possibility that information is forgotten or not conveyed.
- At the conclusion of the bedside report, the off-going nurse and on-coming nurse will co-sign the Bedside Shift Report Handoff Intervention on the worklist in the patient’s electronic medical record.

B. Handoff of the shift to another clinical care provider should occur at the bedside.

- Assuming temporary responsibility for care when the primary nurse leaves the unit for a short period of time (e.g., lunch breaks).
- Transferring a patient from one level of care to another, including admissions from the emergency department.

VI. EDUCATION AND TRAINING:

A. Education is provided during department-specific orientation, annual competencies, and periodically as practices change.

Appendix P

Statement of Non-Research Determination Form

UNIVERSITY OF SAN FRANCISCO | School of Nursing and Health Professions

CNL Project: Statement of Non-Research Determination Form

Student Name: Chona C. Alforque

Title of Project: Standardizing the Bedside Shift Report: Improving Communication and Promoting Patient Safety.

Brief Description of Project: Implementation of standardized bedside shift report (BSR), thereby improving the process of communication during shift changes on the unit.

Nature of the Project: Improve the communication and collaboration among the nurses during shift handoff using SBAR tool to improve patient safety and quality of care.

Data That Shows the Need for the Project: The pre-implementation staff survey was conducted to evaluate the knowledge, attitudes, and comfort level of the nurses of BSR. One question on the survey asked, "How often do you practice bedside reports?" The result showed that out of 40 nurses, 15% of nurses answered "most of the time," 37.5% "sometimes," and 47.5 % "never" practice bedside reports.

Goal of the Project: The goal of the project is to develop a standardized approach to nursing end-of-shift handoffs, which will be achieved by implementing the process of bedside reporting on the ICU to improve nursing communication, and the quality and safety of care, as well as increase patient and staff satisfaction.

Evidence to Support the Project: The Joint Commission introduced a national patient safety goal to implement a standardized approach to handoff communication. Research has shown that the implementation of bedside report medication errors decreased by 80% and there was 100% decrease in patient falls. Standardized bedside report has increased patient safety and patient and nurse satisfaction.

A) Aim Statement: the specific aim is to increase the nurses' compliance with bedside shift reporting on the intensive care unit to 80% within six months of implementation.

B) Description of Intervention: This project involved collaboration between the manager and nurses to create a policy and standardized handoff tools to be implemented along with beside shift reports for all patient handoffs. The interventions include a pre-implementation nurse satisfaction survey, PowerPoint presentation, interviews, and practice scenarios. Following the presentation, a written posttest will be given to check the knowledge of the information presented. A daily huddle at change-of-shift will occur to remind and reinforce BSR. A post-implementation nurse satisfaction survey in six months will be conducted to address any concerns. During the COVID-19 pandemic, practicing beside shift report is on hold.

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C) How will this intervention change practice? Standardized BSR will create a change of shift report process on the unit to improved communication, collaboration, and cohesive teamwork among patient and nurses. The process of bedside reporting allows visualization of the patient during shift change can decrease falls, medical errors, and adverse events. Bedside shift reports will improve patient safety and outcomes and increase patient and staff satisfaction.

D) Outcome measurements: 1) Direct observation of nurses during BSR to calculate how often is being done. 2) Monitor for a decrease in overtime due to more efficient shift-to-shift bedside reports. 3) A review of risk management reports observing for effect on the number and severity of medication errors.

To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used: (http://answers.hhs.gov/ohrp/categories/1569)

☐ This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST *

Instructions: Answer YES or NO to each of the following statements:

Project Title:	**YES**	**NO**
The aim of the project is to improve the process or delivery of care with established/ accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	**X**	
The specific aim is to improve performance on a specific service or program and **is a part of usual care**. ALL participants will receive standard of care.	**X**	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does **NOT** follow a protocol that overrides clinical decision-making.	**X**	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to	**X**	

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ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.		
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	**X**	
The project is conducted by staff where the project will take place and involves a staff who is working at an agency that has an agreement with USF SONHP.	**X**	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	**X**	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/ or patients.	**X**	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: *"This project was undertaken as an Evidence-based change of practice project at X hospital or agency and as such was not formally supervised by the Institutional Review Board."*	**X**	

ANSWER KEY: If the answer to **ALL** of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. **IRB review is not required. Keep a copy of this checklist in your files.** If the answer to ANY of these questions is **NO**, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print): Chona C. Alforque

Signature of Student:
Chona Alforque **DATE:** 5/25/2020

SUPERVISING FACULTY MEMBER (CHAIR) NAME (Please print):

Signature of Supervising Faculty Member (Chair):
Margaret Levine **DATE** 6/4/20