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Improving Nursing Shift Handoff Reports: A Quality Improvement Project

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N653: Internship

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Abstract

Nursing shift-to-shift handoff report can greatly impact a patient's quality of care. According to the Joint Commission, "an estimated 80 percent of serious medical errors involve miscommunication between caregivers when patients are transferred or handed-off" (Inadequate handoff communication, 2017). In total, this quality improvement (QI) project worked with three hospital inpatient units on three different floors in an urban California (CA) city. Each unit and even shifts within each unit varied, leading to the conclusion that interventions should be trialed by units with the most buy-in, then adjusted to the unique needs of each unit. For our main intervention we plan to distribute an educational tool to units focused on the importance of a bedside nursing shift handoff report that highlights TRACER, AIDET, top five aspects to include in a good report, and evidence as to why a bedside report is important. Evaluation of the intervention will be done through a series of data collection methods such as: nurse surveys, patient satisfaction reports and documented adverse events (falls, medication errors, etc.). Within the three months after the intervention, we would hope to see a 30% increase in nurses visiting the bedside during report to perform these key tasks like TRACER, AIDET and engage the client in their own care plan.

Improving Nursing Shift Handoff Reports: A Quality Improvement Project

Nursing shift-to-shift handoff report is an important time that can greatly impact a patient's quality of care. The challenge for the outgoing nurse is to distill what relevant information is needed for the next nursing shift. While many nurses may think they can “wing it” and cover all the important topics, the evidence shows otherwise. The Joint Commission notes that about 80 percent of serious medical errors involve miscommunication between hand-off reports (Inadequate handoff communication, 2017). Similarly, multiple research studies have shown that implementing a standardized process for shift handoff report will lead to cost savings and increased patient satisfaction (Sarvestani et al., 2018; Hurtig et al., 2018). Furthermore, a shift handoff done at the bedside of the patient is linked to increased nursing care quality, greater patient satisfaction and nurse satisfaction (Abbaszade et al., 2021; Elue et al., 2019; McAllen et al., 2018; Sarvestani et al., 2018). This quality improvement (QI) project's goal aligns with Sutter's mission statement of “enhancing the wellbeing of people in the communities we serve” through improving patient safety, nurse report satisfaction and overall patient satisfaction (*Sutter Mission Statement*).

Problem description

According to the Joint Commission, “an estimated 80 percent of serious medical errors involve miscommunication between caregivers when patients are transferred or handed-off” (Inadequate handoff communication, 2017). These miscommunications that occur during handoff report can have drastic impacts on patient care and the hospital's financial bottom line. An estimated 1.7 billion dollars over a period in malpractice costs were associated with these communication failures (Inadequate handoff communication, 2017). Because of this astronomical cost associated with a seemingly simple fix, the Joint Commission recommended

that organizations adopt a standardized approach to handoff reports.

To better assess the problems associated with handoff reports in this particular microsystem, our QI group designed and distributed a survey that asked, among other questions, “What do you feel makes an effective shift-to-shift report, from your experience?” and “What would you like to see be implemented differently during shift-to-shift report?”. In looking at our survey results, the main areas of improvement revolved around improving the efficiency of each report through tools that help nurses remember the important information (such as last recorded bowel movement) and creating an atmosphere during report that is not rushed yet still incentivizes efficiency and accuracy. As one nurse who took the survey described, a good report has “no fluff”. Other responses mention inadequate time for a thorough report and a preference for a head-to-toe bedside report. Perhaps there is a middle ground where both groups can be satisfied with the handoff report.

The three microsystems studied each had their own strengths and weaknesses. Nursing styles differed from unit-to-unit as patient populations also varied. While standardization of the handoff process was recommended by the Joint Commission, the varied survey results, and different experiences within different units complicated the project. In total, we worked with three hospital inpatient units on three different floors for this project. Of these three units, all have three shifts of nursing staff: morning, evening and night. During the transition from night to morning shift, there is quite a lot of time pressure placed on these nurses due to the bulk of client medications scheduled for the morning between 7:30am and 8:00am.

Oppositely, during the shift from evening to night, there is much more time for transition but given that the change occurs at 11:00pm, most clients are asleep at that time, and it would be inappropriate to give a bedside shift report that interrupted a client's sleep. While each shift

creates its own culture around handoff report, the same could be said about different microsystems.

Overall, a one-size-fits-all solution to improving shift report in these three microsystems does not seem to be the best way forward. If we aim to improve patient satisfaction and reduce communication errors that could later result in death and malpractice costs, solutions should be tailored to each microsystem and shift group. In regard to patient satisfaction, one study showed that improving nurse handover through a similar QI process improved patient satisfaction scores for 12 nurse participants from 35% pre-intervention to 80% after the intervention cycles. During Plan Do Study Act (PDSA) cycles, nurses reflected on their experiences and designed an operational plan in addition to participating in two workshops for empowerment in the nursing handover process (Sarvestani et al., 2018). For our QI project, we hope to improve patient satisfaction and reduce communication errors that could ultimately lead to adverse events through similar intervention-based PDSA cycles.

Available Knowledge/Literature Review

There are numerous sources that support the recommendations of this quality improvement project. To initiate our research, we developed a PICOT (Patient Intervention Comparison Outcome Time) Question and began searching for research. During the research process we used these keywords: shift report, nursing handoff, patient satisfaction, handoff, tools, communication, SBAR, IPASS, patient care, improved outcomes, incident report. Our PICOT question is as follows:

During shift-to-shift nursing handoff reports at urban inpatient units in a hospital in California (P), how does the use of standardized evidence-based reporting tools (I) compared to the non-standardized reporting methods currently practiced (C) affect the patient care as

measured by patient satisfaction surveys and communication errors resulting in incident reports (O) within 4 months (T).

Upon completion of the literature review, numerous studies cited benefits to nursing bedside handoff including: improved nurse-patient relationship, improved patient knowledge about their condition, decreased medication errors, decreased number of falls. enhanced interprofessional communication, overall increased nursing care quality, increased patient engagement and participation in care (Abbaszade et al., 2021; Elue et al., 2019; McAllen et al., 2018; Sarvestani et al., 2018). One such study covered 41 articles related to the use of bedside shift report and found that 49% of these saw an improvement in the patient's experience at the unit. This documented finding coincides with the literature review as about half the articles related to patient satisfaction while the other half related cost effectiveness, nurse efficiency and nurse satisfaction.

Within the literature review process, several articles discussed the need for a standardized shift report process that included the utilization of a standardized tool to aid the nurse in remembering to share all the pertinent information (The Joint Commission, 2017). It is particularly important to bring up the Sentinel Alert Event by the Joint Commission because this article has caused organizations to prioritize standardization and implementation of bedside handoffs in their hospital(s). This alert created a recommendation that all hospitals standardize their report process to decrease communication errors. After 2017, there was a spike in the number of QI projects revolving around the topic of shift report standardization. Two of the standardized processes that were developed were found to increase patient safety and improve patient satisfaction scores.

One of these commonly used tools focused on the acronym SBAR. SBAR stands for

Situation, Background, Assessment and Recommendation. That study used a quality of patient care scale (QUALPACS) to assess how well the SBAR tool improved quality of care. The finding was that it improved quality in all measured dimensions (Abbaszade et al., 2021). Similarly, a QI project that focused on medical-surgical floors also found that standardization using SBAR reporting improved patient safety and nurse “perception of communication” after an educational intervention (Usher et al., 2018).

Another tool used to improve the handoff report was IPASS. IPASS is a mnemonic used in handoff to remember “illness severity (I), patient summary (P), action list (A), situational awareness and contingency plans (S), and synthesis by the receiver (S)” (Blazin et al., 2020). While IPASS was developed for use by clinicians handing off their patients to the next clinician on staff, research shows that this format can be applied to many different handoff scenarios (Starmer et al., 2017). This mnemonic has led to significant reductions in medical errors and adverse events across nine pediatric hospitals and saw strong adoption percentages (87%) among inpatient nursing units (Blazin et al., 2020).

Further research of the literature to include the financial aspect of implementing these standardized report systems showed significant potential cost savings due to these previously cited reductions in medical errors, adverse events, and overall increased patient safety (Hurtig et al., 2018). One study from Iran highlighted that post intervention strategies reduced overall costs by \$309,641 and increased patient satisfaction from 35% to 80% thus increasing the cost effectiveness of the intervention by 45% (Sarvestani et al., 2018). Over an entire year, one researcher estimated a cost savings of 6.8 billion dollars through this reduction of adverse events and medical errors (Hurtig et al., 2018).

In order to further reduce medical errors and adverse events with particular attention to

falls, many research articles advocated for the implementation of a bedside report rather than the traditional report given at the nurses' station (McAllen et al., 2018; Williams et al, 2018; White et al., 2018). While the bedside report was often perceived as longer to some nurses, in practice, statistics showed that these reports were not statistically different on average (McAllen et al., 2018).

One study found that Hispanic and public insurance patient populations had statistically significant improved patient satisfaction scores ($p < .001$) due to implementation of bedside reports (Elue et al., 2019). While there was overwhelming evidence to support giving a bedside report, there were some negative comments made by nurses about bedside reports stating "you can get stuck in a room". Others state the patient disrupts the report process with many requests and interruptions (McAllen et al., 2018).

Overall, providing written guidelines about shift report expectations and sufficient education about those guidelines can improve structure, process, and quality management of the handoff report (Kim et al., 2020). However, it can be challenging to implement these guidelines through a top-down leadership approach. Nurse reports at the bedside implementation have been shown to be unsuccessful when there is lack of employee buy-in and inconsistency with the management processes leading to inconsistencies with the new intervention (Dorvil, 2018). Guidelines for implementing a successful intervention include conducting staff meetings, obtaining ongoing nursing feedback, identifying barriers to the new practice, encouraging adherence to the new reporting process through positive reinforcement, and continuously monitoring compliance rates (Dorvil, 2018).

Rationale

Lewin's theory of change framework was used to approach the QI project. This change

theory states that “individuals and groups of individuals are influenced by restraining forces, or obstacles that counter driving forces aimed at keeping the status quo, and driving forces, or positive forces for change that push in the direction that causes change to happen”. This theory describes change in three stages: unfreezing, change and refreezing (Petiprin, 2020).

The first goal of this project was to unfreeze any practices not currently supported by evidence. Then, the behavior needs to be reshaped toward best practices and the refreeze of that new behavior. As simple as that may sound, there are many barriers to nurses changing their behaviors. Some strategies we could use to create that unfreezing step are to increase the driving forces that direct behavior away from the status quo and simultaneously decrease forces of resistance (Petiprin, 2020). Practically speaking, this could look like incentives for people that perform excellent bedside reports while simultaneously providing education to healthcare staff on the important impact that these bedside reports offer to potentially change minds of those more hesitant to change.

Specific Project Aim

We aim to improve the bedside shift reporting system for inpatient units at an urban hospital in California. The process began with a literature review to identify best practices that have helped improve these reporting systems at other facilities and observation of the current practices and tools used currently by bedside staff. The process ends with a report to the Nursing Professional Practice Council and Nursing Quality where we will present findings and recommendations for implementation of evidence-based tools through staff collaboration that identify ways communication practices can be improved. By working on this process, we expect to improve communication of essential information from shift to shift which will enhance individual patient safety, nurse satisfaction and patient satisfaction (Dorvil, 2018; McAllen et. al,

2018).

It is important to work on this now because the last few years of the pandemic have caused nursing shortages and burnout. This puts a larger strain on current staff to work well as a team to avoid major mistakes in care. As new staff are brought in, creating a culture of improved communication through evidence based best practices will support new staff in building good communication habits. Likewise, communication will improve patient and nurse satisfaction with the handoff process in addition to reducing medical errors associated with communication, thus improving patient safety (Starmer, 2017).

Context

There are several different microsystems under the purview of this QI project. Each of the three microsystems are hospital inpatient units at an urban hospital in CA and all units fall under the general medical-surgical umbrella with varying specialties. For example, the sixth floor received most of the post-operative patients, while the fifth floor received elders requiring additional care in areas such as memory and ambulation support. In addition to these systemic differences between floors, the staffing within each microsystem created different dynamics, both positive and negative.

Interventions

For our main intervention we plan to distribute an educational tool to units focused on the importance of a bedside nursing shift handoff report that highlights TRACER, AIDET, top five aspects to include in a good report, and evidence as to why a bedside report is important. It is important to note that interventions and expectations should be tailored to individual units and first championed by units with the most buy-in. There are many different ongoing QI projects at this hospital of higher priority. Additionally, some units are still in the process of bringing on

newly hired staff. Once all staff are onboarded, the intervention can be delivered to everyone in one round of education.

In addition to this main educational intervention, we would like to create dialogue about this topic through one-to-one education with nurses and coaching support about how to best help individuals make the needed habit changes. By creating space for these one-on-one conversations, we can identify leaders in each unit who can help shift the staff culture towards better communication habits. Similarly, the conversations will allow us to identify individuals who need more support in making this shift in their reporting habit.

Study of Intervention

After the intervention, we would hope to have a significant increase in the audit scores for the shift report. This would indicate that nurses took the time to meticulously go through each patient and give necessary handoff information. To study this intervention, we hope that future groups utilize our same audit tool so that results of future interventions can be compared with our established baseline. In addition to observations to evaluate the interventions, we originally planned to compare this data subjectively and objectively. For subjective analysis, we planned to have conversations with nurses and compare current and future patient satisfaction surveys. For objective data, we wanted to compare the pre-intervention number of communication-based MIDAS reports with post-intervention MIDAS reports. This will help us identify any changes in patient safety as well as patient and nurse perception of the new standardized system.

Measures

Evaluation of the intervention will be done through a series of data collection methods such as: nurse surveys, patient satisfaction reports and documented adverse events (falls, medication errors, etc.). These measures will be used to identify new top priority items for

inclusion in the shift report. Using our audit tool results we have identified the top items often missed or asked for by the incoming nurse about the patient's status. The top five most missed items in order from most missed to least were: code status, ambulatory status, vital signs, last bowel movement, and intravenous (IV) catheter gauge. Just outside of the top five most missed topics to mention in report were blood sugar checks, next pain med due and skin checks.

To better educate staff on all three of these units, we recommend sharing this educational pamphlet (Appendix D) and use one-on-one or group classes to help disseminate the information and its importance to the nursing profession.

Results

In total, of three units, all units had different shift and unit cultures. Different shifts had slightly different norms based on the personnel of how a handoff report was given. One nurse interviewee, who had recently started working on a unit within our study purview, mentioned that her old hospital culture always included a bedside report for evening shift but here it was hardly ever the norm. She added, in her unit, other factors disrupted the ability to give reports at the bedside consistently for all patients like sleep or visitors. However, she simultaneously acknowledged that it is not necessarily an excuse to never give handoff reports at the bedside.

It was clear that some units had nurses that went above and beyond with their shift handoff while other units had inexperienced nurses that had never been trained on how to give a proper shift report. At the other extreme, one floor had many nurses with many years of experience who had ingrained habits of giving reports. Their methods had not been updated in years, often leading to ineffective and subpar communication between shifts.

We would hope to see a 20% increase in compliance after the intervention has been distributed amongst the nursing staff. Within the three months after the intervention, we would

hope to see a 30% increase in nurses visiting the bedside during report to perform these key tasks like TRACER, AIDET and engage the client in their own care plan.

Summary

During this project, we were able to successfully identify areas for needed improvement during the nurse shift-to-shift report with evidence to support these changes. We developed resources such as the audit tool and education pamphlet to further aid the ongoing unfreezing process. While the process of change can be slow, we saw greater potential for change within units particularly on the sixth and fifth floors. Implementation of this project should start with education on the evidence and continue with observations to identify unit champions that can help shift unit culture towards a more standardized report process that includes a bedside portion of report.

Conclusion

In the first three months of this project, we had success at reviewing the evidence-based literature, collecting data to support that literature and educating staff through conversations and surveys about bedside reports. Evidence supports bedside handoff reports citing benefits like: improved nurse-patient relationship, improved patient knowledge about their condition, decreased medication errors, decreased number of falls. enhanced medical care team communication in regards to patient safety, overall increased nursing care quality, increased patient engagement and participation in care (Abbaszade et al., 2021; Elue et al., 2019; McAllen et al., 2018; Sarvestani et al., 2018).

While the implementations of our intervention ideas did not come to fruition in the time scale that we had hoped, we were successful at creating educational materials for future groups who take on this project. During our preliminary observations we noted that this project was one

of many QI projects attempting to be implemented at the same time. Additionally, this project, while important in the long run, was not the highest priority to the management teams. This result coincides with previous research that noted challenges of implementation when there is lack of employee buy-in and inconsistencies with management processes and intervention (Dorvil, 2018). Nurse buy-in on the topic was mixed and varied heavily during the different floors and shifts. Anecdotally, newly hired nurses showed more interest to improve their shift report by incorporating bedside handoff either because they came from hospital systems that had a culture of bedside handoff or they had not had any training on shift report and were intrigued to hear about newer research to improve care outcomes.

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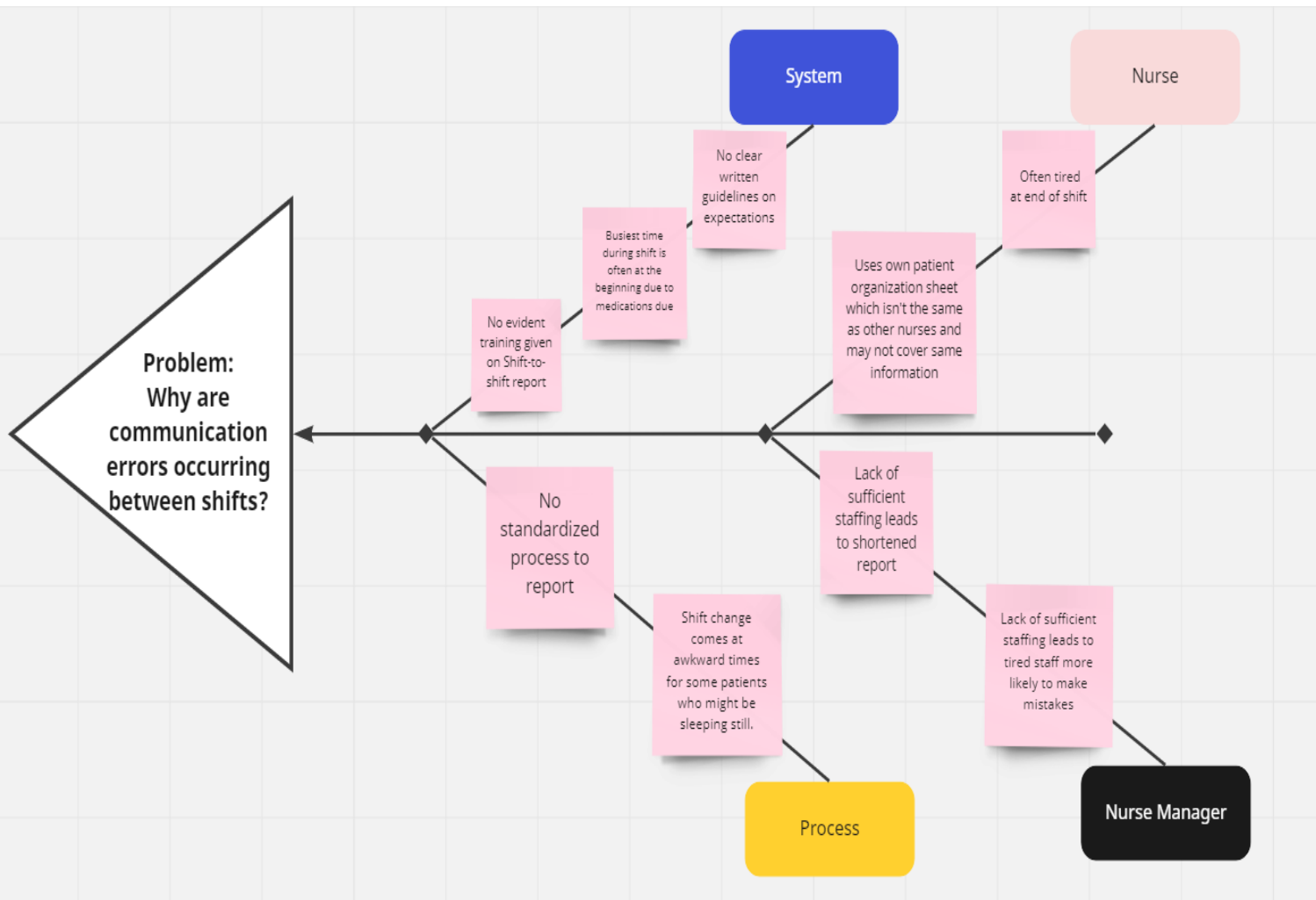
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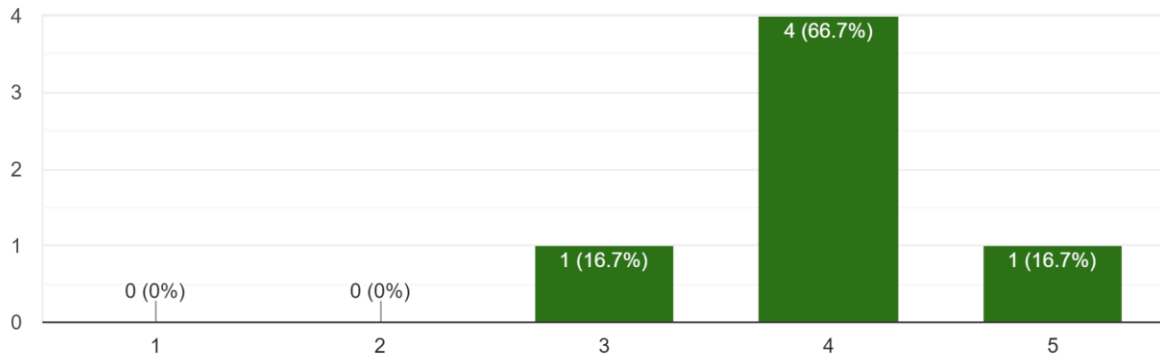
Appendix A



Appendix B Survey Results

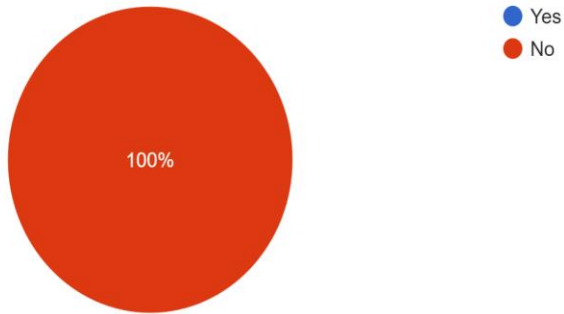
Please rate your satisfaction on how shift-to-shift reports are currently being conducted.

6 responses



Do you currently conduct shift-to-shift report at the bedside?

6 responses



Appendix B cont. Questions

What current methods/tools do you utilize to deliver your shift-to-shift report? (ex. EPIC, SBAR, AIDET, TRACER, etc.)

6 responses

None

SBAR

Epic, Sbar

unit provides report sheet

Epic

What do you think makes an ineffective shift-to-shift report, from your experience?

6 responses

Too much fluff and not enough substance. If it's not relevant to the current situation and discharge/admission it is not necessary. SBAR is a mnemonic for a situation that needs an answer, not shift reporting

Nurses who are rushing and not leaving time for questions.

An unexperienced nurse, nurse not knowing labs, nurse not knowing last BM, call light interruptions due to poor staffing at change of shift, calls from lab between 7-7:30

having to be bedside in front of pt

Not bedside report

Too much unnecessary crap.

Appendix B cont. Questions

What do you think makes an ineffective shift-to-shift report, from your experience?

6 responses

Too much fluff and not enough substance. If it's not relevant to the current situation and discharge/admission it is not necessary. SBAR is a mnemonic for a situation that needs an answer, not shift reporting

Nurses who are rushing and not leaving time for questions.

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having to be bedside in front of pt

Not bedside report

Too much unnecessary crap.

What would you like to see be implemented differently during shift-to-shift report?

6 responses

Whatever it is it should not be longer than 2 minutes per pt. Less if it is a standard ER pt.

For someone to be answering call lights for patients while we are giving report.

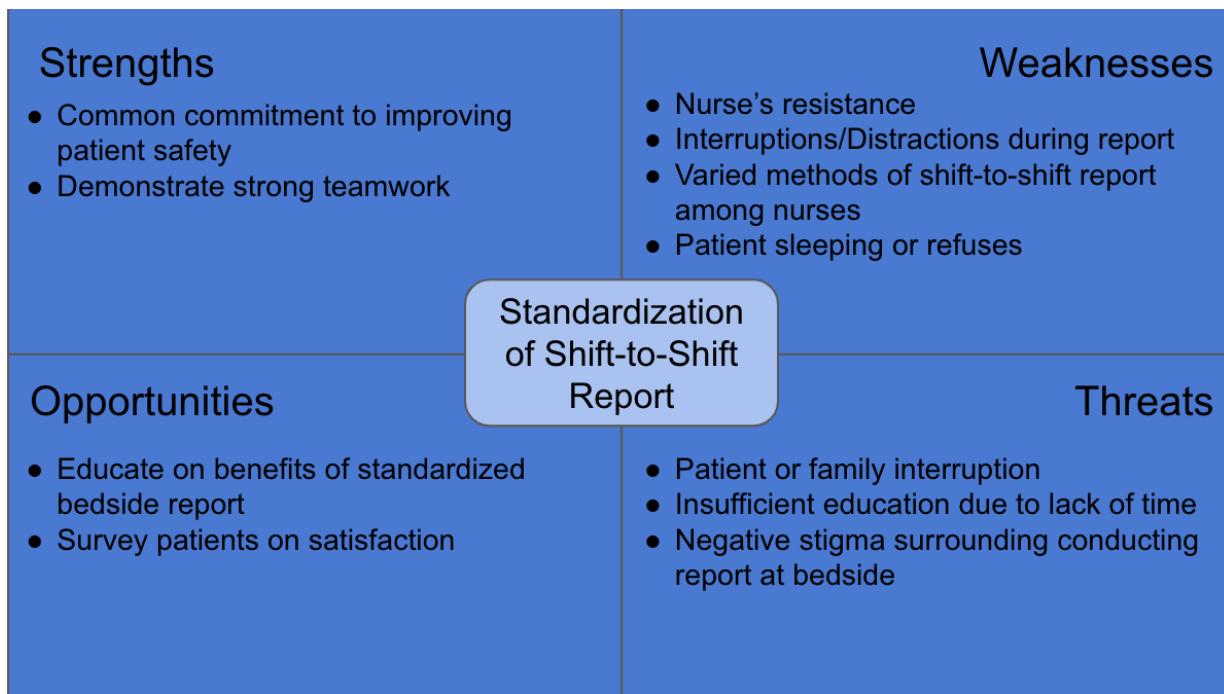
No calls from 7-7:30, no huddles during that time as well. Have last known BM reported as standard.

use emr for report

Bedside report

A timer. Anything over 1-2 minutes and I've stopped listening.

Appendix C: SWOT Analysis



Appendix D: Educational Pamphlet

TOP 5 TOPICS FORGOTTEN DURING SHIFT-TO-SHIFT REPORT



WHAT TO DO AT THE BEDSIDE?

| | |
|---|---|
| T RACE existing lines from source to site | A CKNOWLEDGE Greet patient by preferred name <i>Increase Safety</i> |
| R EAD existing line labels | I NTRODUCE yourself by stating name and title <i>Increase Trust</i> |
| A FFIX labels when/where required | D URATION Tell pt. how long processes will take <i>Decrease Anxiety</i> |
| C ONNECT compatible lines without forcing or adapting connectors | E XPLANATION what you will be doing for them <i>Increase Compliance</i> |
| E XAMINE the new connection | T HANK YOU Thank your pt. for allowing you to care for them <i>Increase Loyalty</i> |
| R ETRACE and confirm source to site | |

Evidence shows that Bedside Report:

- Builds Trust and Rapport
- Patients can be active partners in care
- Decreases number of falls & med errors
- Promotes a culture of collaboration
- Increases patient satisfaction

When not to do bedside report:

1. Patient on Airborne precautions
2. Patient is actively agitated
3. Family/friends visiting
4. Patient is asleep after being restless
5. Low stimulation indicated

What to Do When Bedside Report is Not Appropriate

- Complete report outside room so patient & equipment is visible
- Introduce nurse to patient following report (if possible)
- Point out important equipment after report quietly or from door frame
- Review existing orders and emphasize most important to oncoming nurse

