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Improving the Quality of Bedside Shift Report Behavior: Implementing a Standardized Bedside
Report Tool on the Medical-Surgical Floor at Woodland Healthcare

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Improving the Quality of Bedside Shift Report Behavior

Nursing handoff communication at change-of-shift is a frequent, yet highly essential nursing responsibility that lays the foundation for providing care that is safe and consistent (Grimshaw, Hatch, Willard, & Abraham, (2016). According to Zou and Zhang (2016), the Joint Commission (TJC) has evaluated that the leading cause of sentinel events is a result of poor nursing communication during patient handoffs. In alliance with the National Patient Safety Goals to improve the effectiveness of communication between caregivers, organizations such as the Agency for Healthcare Research and Quality (AHRQ) and World Health Organization (WHO) have identified the importance of addressing patient safety risks associated with poor handoff communication as a priority and have established recommendations to improve upon this issue (Grimshaw, Hatch, Willard, & Abraham, 2016).

The medical-surgical unit at Woodland Healthcare (WHC), a small community hospital that serves Yolo County, consists of a 35-bed unit with twenty twelve-hour night shift nurses on staff. The inability of medical-surgical nursing staff at WHC to deliver quality BSR may have a significant negative impact on patient outcomes. Furthermore, poor communication may result in delayed or inappropriate treatment, unplanned extended length of stay (LOS), unnecessary spending on preventable costs, decreased patient and staff satisfaction, and ultimately-- patient harm (Scheidenhelm & Reitz, 2017). In an effort to improve the quality of nurse-to-nurse communication and prevent errors at WHC, this paper will discuss an evidence-based focused project aimed at enhancing the quality of BSR of twenty twelve-hour night shift nurses on the medical-surgical unit through implementation of a standardized BSR tool (see Appendix A).

Clinical Leadership Theme

Clinical leadership improvement themes identified throughout this project include safety, communication, and both patient and staff satisfaction. A global theme statement is as follows: We aim to improve the quality of change-of-shift handoff communication on the medical-surgical unit at WHC through the implementation of a standardized BSR tool that addresses five key nursing behaviors including preparation, introduction, information exchange, patient involvement, and a safety scan. The process begins with the proper preparation of the oncoming nurse and ends with consistent and appropriate delivery of quality BSR without incidence of miscommunication resulting in patient harm. By working on the process, we expect 1). improved patient safety 2). improved communication between nursing staff and patients 3). improved patient and staff satisfaction and 4). prevention of unnecessary hospital expenditures. It is important to work on this process now because we have identified the need to improve 1). patient safety through enhanced communication 2). both patient and staff satisfaction 3). prevention of communication related errors at change-of-shift.

This project integrates clinical nurse leader (CNL) competency *Quality Improvement and Safety*, Essential 3 as a framework which is described by the American Association of Colleges of Nursing (AACN) (2013) as utilizing “performance measures to assess and improve the delivery of evidence-based practices and promote outcomes that demonstrate delivery of higher-value care” (p.12). As a CNL- Master’s prepared student working towards implementation of this project, I will function in the role of both Risk Analyst/ Anticipator and Team Manager, in accordance with the End of Program Competencies outlined by the University of San Francisco (USF) (2017), thereby conducting a microsystem analysis and utilizing evidence-based practice to implement a process for improving safety. Additionally, during this project I will identify

clinical and cost outcomes related to poor communication during shift report in an effort to raise awareness regarding improving safety, efficiency, and quality of patient-centered care.

Statement of the Problem

Ford and Heyman (2017) describe patient handoff as process that includes the transfer of patient care responsibility from one care provider to another. It is during this time that patients are most vulnerable and susceptible to experiencing communication related errors. Upon observation of the targeted process in the clinical microsystem, night shift nurses lacked providing quality BSR, and in some instances lacked performing BSR at all. Instead shift report took place outside of the patient's rooms, at the nurse's station, or in the hallways. This CNL project acknowledges the potential barriers yielded by a pre-implementation nursing survey which revealed nursing attitude, feelings, and perceptions regarding aspects of BSR performance or lack thereof. Nurses felt that performing a quality BSR depended upon time, staff attitude or resistance, concerns of violating the Health Insurance Portability and Accountability Act (HIPPA), language barriers, and patient compliance.

Patient handoff is a commonly practiced method for communicating critical information during change-of-shift report, however, we must consider if the quality in which BSR is being performed has an effect on care that is safe and appropriate. If conducted correctly, BSR allows the opportunity for the oncoming nurse to catch, clarify, and correct errors early on which could otherwise have been easily overlooked. The purpose of this project is to implement an evidence-based derived practice to establish a standard for quality BSR in an effort to prevent errors, improve patient safety through adequate communication, decrease unnecessary costs, and increase patient and staff satisfaction.

Project Overview

The overall goals of this CNL project is to prevent errors that lead to patient harm. Additionally we aim to improve communication between nurses, decrease LOS, decrease unnecessary costs, and improve patient and staff satisfaction. Furthermore, improvement to this process will encourage nursing accountability, boost nursing morale and teamwork, and foster a culture of safety throughout the continuum of care. Ulrich (2017) explains that in a “Just Culture,” three types of errors are recognized- human error, at risk behavior, and reckless behavior and that leadership is to respond to such errors with fact finding and systems improvements rather than blaming and shaming individuals (p. 207). The CNL competency that aligns with the ideals of a Just Culture is Essential 3- Quality Improvement and Safety which supports the promotion of a culture that continuously focuses on quality improvement within a system (American Association of Colleges of Nursing, 2013).

A specific aim statement has been developed for this project and is as follows: Through the implementation of a standardized bedside report tool, 95% of twelve-hour night shift nurses on the medical-surgical unit will demonstrate proper quality bedside report at shift change by August 15, 2017. This specific aim statement supports implementing a standardized BSR tool at WHC because the medical-surgical nurses will be able to communicate relevant information in a consistent and succinct manner, participate in two-way communication utilizing electronic health records, physically assess the patient, environment, equipment, and have the opportunity to interact, involve, and engage the patient in their own care. This process addresses the global aim statement to improve patient safety through enhanced communication, improve both patient and staff satisfaction, and prevent reportable events.

Rationale

This CNL project focuses on a process improvement that is both patient and staff driven and will follow the recommendations of the Dartmouth Microsystem Improvement Curriculum (DMIC) which includes a microsystem assessment, development of theme, global aim, specific aim, change ideas, and measures through the Plan-Do-Study-Act (PDSA) model (Nelson, Batalden, & Godfrey, 2007). Upon completion of a clinical microsystem assessment of the medical-surgical unit at WHC utilizing the 5 P's (Purpose, Patients, Professionals, Process, and Patterns), only 10 out of 20 (50%) medical-surgical nurses participated in BSR after a twelve-hour night shift and of these ten staff nurses, only six included the criteria of a quality BSR. Ferguson and Howell (2015), explain that proper implementation of BSR includes a five step process: preparation, introduction, information exchange, patient involvement, and a safety scan. This means that only 6 out of 20 (30%) of night shift staff nurses demonstrated appropriate preparation, introduced themselves to the patient, included the patient in report, updated the whiteboard, utilized the electronic health record (EHR) in the room, performed a verbal/visual assessment and SBAR (Situation, Background, Assessment, and Recommendations) report, and performed a safety scan.

Moreover, recent reportable events have occurred related to patient safety as a result of poor handoff communication at shift change which could have been prevented if a quality BSR was performed. In one instance, a Foley Catheter was kinked, with no recorded urine output by the night shift nurse. It is apparent that during change-of-shift report, the off going and oncoming nurses did not assess drains or tubes which resulted negatively impacting patient care. Once the day shift nurse realized the Foley catheter was not producing urine output, she unkinked it to find that the patient was holding 1,000 mL of urine in their bladder. In this case, the patient could

have inexcusably suffered from an electrolyte imbalance, catheter-associated urinary tract infection (CAUTI), a ruptured bladder or even died—overall putting the patient in way of harm. An incident like this, not only leads to unnecessary expenditures on the organization's behalf, but could have resulted in a law suit for negligence. Unfortunately, this particular patient required additional lab testing which costs \$500 and an extended night stay for observation costing \$4,000, resulting in a total of \$4,500 additional costs absorbed by WHC. With implementation of a standardized BSR tool, this incident could have been easily avoided altogether. Nurses would be expected to assess all drains, tubes, wounds, IV lines to ensure proper functioning and status.

Another reportable event that has occurred on the medical-surgical unit at WHC includes a patient fall related to poor handoff communication. During shift change, the night shift nurse reported that a bed alarm was activated for an unsteady elderly patient who was eager to get out of bed on her own. Soon after change-of-shift, the patient experienced a mechanical fall. This was a result of poor hand-off communication as shift report was not completed at the bedside. Upon further investigation, the day shift nurse found that the bed alarm never sounded because it was not activated. If both the off going nurse and oncoming nurse made time to assess for environmental safety during BSR, this incident may have been avoided. This unfortunate event caused the patient to suffer a soft tissue injury, which required additional diagnostic testing such as an x-ray of the hip which costs upwards of \$500.00, a physical therapy evaluation costing approximately \$200, pain medication expenses costing \$500, and an extended stay for observation for at least one more night costing the hospital \$4,000. This incident alone would cost the organization a total of \$5,200 in unnecessary expenses. It is important to acknowledge how this sentinel event negatively reflects on WHC in regards to state regulations. It is possible that this incident could result in a fineable violation due to substandard of care and negligence.

The Joint Commission (2015) reports that standardized practice to prevent falls include utilizing bedside report as an effective handoff communication tool. Safety, according to CMS (2017), is a quality domain measure that has been added for fiscal year 2017 and accounts for 20% of reimbursement. Since patient falls during hospital stays are considered hospital acquired condition (HAC), WHC would not receive reimbursement due to the value-based purchase program (VBP) set forth by CMS to reward providers for the quality of care that patients receive (CMS, 2017).

Poor handoff communication has led to another preventable event at WHC that could have been avoided by utilizing the components of a quality BSR tool. This particular incident involved a patient with orders to receive continuous tube feedings through a gastrostomy tube (G-tube) which required point of care fingersticks to test blood glucose every four hours. The night shift nurse verbally reported to the oncoming day shift nurse that she had resumed the tube feedings on a Kangaroo pump after administering medications through the G-tube during the night, however, upon assessment the day shift nurse found the patient to be hypoglycemic. The nurse discovered that the continuous tube feeding was not hooked up or running as verbalized by the previous nurse. If a quality BSR was performed at change-of-shift utilizing a BSR tool, this incident could have also been easily avoided. Visual inspection of the patient by both nurses would have allowed the opportunity to catch this event early on. This event led to additional costs to the organization as laboratory testing costs \$500, hypoglycemia medications costs \$800, and an extended LOS of at least one to three days for observation costs up to \$12,000 resulting in a total of \$13,300.

All three previously stated incidence costs WHC a total of \$23,000 in expenses which could have been either avoided or caught early enough to prevent patient harm. Refer to

Appendix B for cost analysis. Poor handoff communication not only directly effects quantifiable costs at the hospital's expense, but also puts patients in a position to unexpectedly endure emotional pain and/or physical suffering. Also, these events can negatively interfere with daily lives and impact both patient and staff satisfaction scores as we must not forget the possibility of personal financial hardship or strain on personal and professional relationships that may occur. Implementing a standardized BSR tool could potentially save WHC thousands of dollars and it would come at no cost to the organization. Not only are nurses allocated time during their shift to perform BSR as a part of a daily nursing responsibility, it is important to point out that there are zero costs for my services as a CNL student as I will be unpaid to complete this project. My services would include data collection, education/in-services with nursing staff, coaching/mentoring, and monitoring and evaluating the effectiveness of the BSR tool.

Methodology

As a prospective CNL, I intend to utilize evidence-based research and Lewin's Theory of planned change as the theoretical framework to guide and drive implementation of the BSR tool. Lewin's framework is composed of three phases: unfreezing, moving, and refreezing (Scheidenhelm & Reitz, 2017). During the unfreezing stage, I plan to present evidence-based research that supports utilizing a BSR as best practice for handoff communication, address staff barriers, and provide education to nursing staff regarding the benefits of utilizing a standardized BSR tool to improve patient safety, increase patient and staff satisfaction, and reduce unnecessary spending on behalf of WHC. During the moving phase, I will begin to monitor and mentor nursing staff during BSR at change-of-shift and act as a resource to support and encourage nurses to adopt change. Lastly in the final stage of unfreezing, it is my goal to

evaluate BSR as a sustained process during handoff communication, thereby no longer dependent upon my consistent coaching in order to be successful.

In an effort to empower nursing staff to embrace this method of consistent handoff, I am planning to provide education/in-service through huddles, coaching and mentoring, storytelling, present immediate feedback to those in need, and reward those who make an effort to participate in utilizing the BSR tool as an opportunity to improve patient outcomes. According to Rogers Diffusion of Innovation model described by Cain and Mittman (2002), it will be important to recognize early and late adopters, as these are the people who are ready for change and will contribute to its success.

To evaluate effectiveness of the BSR tool implementation, pre- and post-implementation data must be collected and compared. I will perform a bedside report competency check on twenty 12 hour night shift nurses prior to implementation of the standardized BSR tool and then again one month post-implementation to measure for success. The competency checklist will resemble and contain the five categories of the standardized BSR tool including preparation, introduction, information exchange, patient involvement, and a safety scan (Appendix A). Performing a competency check will allow me to evaluate whether or not we have reached the goal of 95% night shift nurses demonstrating a quality BSR by August 15th, 2017.

Furthermore, I will follow up with a staff by comparing the nursing satisfaction survey both pre- and post-implementation to evaluate whether nursing attitude, perception, and satisfaction have improved after BSR tool implementation. Patient satisfaction scores will be evaluated through a Press Ganey survey, which will include categories specifically related to nursing communication and change-of-shift report. Additionally, it is important to also evaluate the number of reportable incidences that occur as a result of poor handoff communication post-

implementation. This will be utilized to measure if implementation of a BSR tool has made an impact in preventing communication related errors during shift change. A root cause analysis (RCA) may be required to address future events and I plan to continue ongoing quality improvement efforts utilizing the PDSA cycle. As a result of implementation a BSR tool, I predict reaching the specific aim of 95% of night shift nurses at WHC demonstrating a quality BSR by August 15, 2017.

Data Source/ Literature Review

The data source focus for this CNL project will consist of a continued microsystem assessment, Press Ganey scores, a nursing satisfaction survey, and a competency checklist. The competency checklist can be found in Appendix D. Utilizing data collected from these sources will allow for the best measures of effectiveness post-implementation. Observed BSR through a competency check will verify that nurses are competent in adequately demonstrating proper change-of-shift report. Patient surveys and staff questionnaires provide valuable insight for assessing project success.

When searching for evidence-based research, I utilized the PICO (Population, Intervention, Comparison, and Outcome) strategy in order to narrow my search down to 552 peer-reviewed articles. The population portion of my search included medical-surgical nursing, intervention was bedside report tool, comparison included on-bedside shift report methods, and outcome included effective communication at shift change as evidenced by improved patient outcomes, prevention of reportable events, and improved patient and staff satisfaction. Academic peer-reviewed journals were used to establish a literature review. Online search engines used included the Gleeson Library Fusion and Ovid database at the University of San Francisco. Key phrases used to search articles included *bedside report*, *bedside handoff*, *patient safety*, *nursing*

handoff communication, bedside shift report tools, standardized bedside report tools in English.

All literature used for this project are dated between years 2013 and 2017.

Ford and Heyman (2017) set out to validate previously founded data suggesting a positive correlation between the frequency of bedside handoff with patient's satisfaction, participation in care, understanding of care, and feelings surrounding safety. Additionally this research article evaluated the effectiveness of bedside report implementation and to assess the effect of bedside report on patient's reported trust in their nurse. A survey was conducted on a five inpatient adult medical-surgical units at a hospital in the Mid-West that targeted nurses who worked 12 hour shifts (Ford & Heyman, 2017). Ford and Heyman (2017) explain that descriptive analysis, ANOVA, post hoc analysis was utilized to determine whether the means of responses differed. Survey responses revealed that 77.9% of patients reported that RNs had "always" conducted BSR, 18.3%, did most of the time, and 2.9% rarely did (Ford & Heyman, 2017). Data from this article suggest that patients who had nurses who "always" performed BSR had positive or improved patient satisfaction scores and that patients reported feeling less safe when BSR was not given and noted three times more inaccuracies in information exchange (Ford & Heyman, 2017). A BSR tool can help standardize the way medical-surgical nurses at WHC communicate with one another and patients. It is important that patients feel safe during their stay in the hospital.

In another research article, Ferguson and Howell (2015) discuss the benefits and challenges of bedside report, address TJC's recommendations which include standardizing patient handoff communication, and explore recent research that supports best practice standards for medical surgical units. In alliance with TJC, Ferguson and Howell (2015) point out the push to facilitate National Patient Safety Goal to promote communication between health

professionals and patients, in which case bedside shift report could be utilized as a pragmatic tool in doing so. During bedside shift report, the authors, express the nurses have the opportunity to clarify significant information and examine patient's physically—including drains, tubes, IV medications, and wounds which serves as an important assessment to improve patient safety (Ferguson & Howell, 2015). BSR allows the opportunity for nurses to perform safety checks and a quick physical assessment to ensure patient safety.

Grimshaw, Hatch, Willard, and Abraham (2016) performed a qualitative phenomenological study and conducted personal interviews with seven acute care nurses to identify the factors and perceptions influencing the frequency and consistency of bedside report during change-of-shift. Synthesis of the data reveals five themes: bedside reporting takes or can take more time, bedside reporting promotes continuity of care, modified bedside report is used, bedside report provides visualization of patient, and nurses cannot say everything at bedside during report (Grimshaw, Hatch, Willard, & Abraham, 2016). The authors deduced that bedside report facilitates patient-centered care that sets the precedent that patient safety is a priority.

Similar to the BSR tool implementation I plan to use, Scheidenhelm and Reitz (2017) utilized a quasi-experimental, between group, pre- and post-implementation comparison of patient satisfaction scores from returned surveys on two units in a 149 bed community hospital after a change in management strategy and standardized evidence-based approach to bedside report was implemented. The purpose of the study was to increase nursing compliance with performing bedside report as well as increase patient satisfaction scores. The authors reveal that the data collected suggests bedside report is an effective method for improving patient satisfaction in regard to nursing communication. Additionally, it was noted that nurse compliance with bedside report increased on both units post-implementation which consisted of

team monitoring and immediate feedback, however, nurse compliance did take longer than the authors expected. Scheidenhelm and Reitz (2017) expressed that the use of Lewin's theory of planned change was effective in increasing nursing compliance with bedside report which included nurse education, addressing barriers, standardizing the process, monitoring, and providing support from leaders.

Small and Fitzpatrick (2017) studied a total of 84 nurses at two academic hospitals in Northeast Ohio on two 36-bed medical surgical units utilizing a qualitative online survey titled NABSR to examine the positive and negative perceptions and to identify the barriers related to the implementation of bedside report. The data shows that the nurses felt that bedside report significantly increased accountability, patient safety, and patient involvement in care (Small & Fitzpatrick, 2017). In the cases of reportable events that have taken place at WHC, implementing a BSR tool could increase nurse accountability and provide an opportunity to enhance patient safety and involvement in care.

Standardizing communication based on evidence-based practice is an effective approach to improve communication during handoff (Zou & Zhang, 2016). Zou and Zhang (2016) evaluate the effectiveness of a standardized nursing handoff form (NHF) utilizing a 1-group pretest-posttest quasi-experimental design which was conducted on an inpatient medical unit over an 11 month period and the authors suggest that in comparing pre- and post-implementation data, there was an overall decrease in nursing error rates from 9.2 to 5.7 (per 100 admissions) and a decrease in the total errors from 180 to 122 (Zou & Zhang, 2016). Furthermore, post implementation of the NHF, handoff related significantly decreased from 2.7 to 0.3 (per 100 admissions) (Zou & Zhang, 2016). The authors of this article feel that the findings of this study

indicate that the implementation of a standardized handoff tool, much like that of the BSR tool, can improve nursing handoffs and reduce handoff related errors.

Timeline

This project began in late May and will extend until the middle August. See Appendix F. The planning, education, and implementation of the standardized BSR tool will take approximately three months. Phase one began May 23, 2017 with a clinical microsystem assessment of the medical-surgical unit at WHC utilizing the 5Ps. During this time, I performed a needs assessment and discovered a lack of BSR as a standard of handoff communication process. Nursing staff questionnaires were conducted by May 28, 2017 to assess nursing barriers and perceptions regarding performing BSR. By June 6, 2017 change-of-shift reporting behaviors were observed on twenty night shift nurses until June 20, 2017. Evidence based research began May 28, 2017 and continued through July 11, 2017.

By July 6, 2017, in-service and education will be provided to night shift nursing staff regarding the benefits of utilizing a BSR tool to improve communication. Furthermore, implementation of the BSR tool is to take place beginning July 11, 2017 through August 5, 2017. Post-implementation data will be collected two weeks after which will include competency checks on all twenty night shift nurses by August 15, 2017 in an effort to evaluate outcome measures.

Expected Results

Positive results will be highly dependent upon adoptability, influence, and acceptance towards implementing a standardized BSR tool to enhance communication. I have already begun to gain stakeholder support and interest from the unit manager and administration and therefore, I presently imagine positive results to be a reflection of these trusting relationships. The inherent

desire to provide patients with exceptional care is a shared goal amongst the nursing staff at WHC, and therefore as a result of this project, teamwork and unity might emerge even more so than before. The idea that nursing care does not begin or end with a shift, but is rather a 24 hour business is an important concept to grasp. Although a nurse has clocked out for the day and is able to go home, patients remain in the same place they were left and deserve care that is safe and consistent on their behalf.

Nursing Relevance

Poor patient outcomes as a result of sub-standard care is not only avoidable, but unacceptable. Estes (2016) explains, patient advocacy is embedded in the foundation of the nursing profession. It is essential to acknowledge the importance of integrating and inspiring patient advocacy in daily practice. Implementing this process will allow nurses the opportunity to visually inspect patients and their environment, clarify and address concerns utilizing the electronic healthcare record (EHR), take accountability for nursing actions, enrich teamwork and build trusting relationships, and proactively engage patients and their families in an individualized plan of care.

Furthermore, nursing staff has the ability to demonstrate patient advocacy by participating in utilizing the suggested BSR tool derived from evidence-based practice. I am hopeful in achieving and further developing a strong sense of unity, teamwork, empowerment, and nursing accountability not only on the medical-surgical unit, but throughout the entire WHC organization. Patient safety is, and should remain a priority in every aspect of care that is delivered—and handoff communication is no exception. Healthcare professionals should continue to strive towards excellence as a team.

As a prospective CNL, it is my duty to act as an advocate, mentor, coach, and resource who fosters a culture of safety in an effort to continuously improve patient outcomes. Facilitating this behavior by nursing staff is an example of how a CNL exhibits competency 9: Master's Level Nursing Practice, number 12 which states that the CNL shall "Advocate for patients within the healthcare delivery system to effect quality, safe, and value-based outcomes" (American Association of Colleges of Nursing, 2013, p. 21). As a result of implementing this evidence-based derived change, nurses are inspired and empowered to express concerns and are unafraid to question decisions on behalf of their patients as this is an example of nurses consistently placing patients at the forefront of concern.

Summary Report

The overall specific aim of my CNL project is as follows: Through the implementation of a standardized bedside report tool, 95% of twelve-hour night shift nurses on the medical-surgical unit will demonstrate proper quality bedside report at shift change by August 15, 2017. To date, I have performed a microsystem needs assessment, observed and collected data specific to BSR during shift change, performed evidence-based research, assessed barriers to implementing a BSR tool, and utilized methods to implement a BSR tool through staff education, storytelling, and huddles.

Initial baseline data revealed that only 6 out 20 night shift nurses were performing a quality shift report according to evidence-based practice. Additionally, as a result of an initial nursing satisfaction survey regarding BSR, only 40% of day shift nurses felt satisfied with shift report and 30% of night shift nurses felt that they had adequate time to deliver report. There were three reportable events that led to avoidable costs to WHC as a result of poor communication during shift report. Press Ganey scores showed a mean of 89.3 percent of patient's felt included

in the plan of care during change of shift, and although this number does not reflect poorly on WHC, there is room for improvement. Upon further assessment of Press Ganey scores (WHC, 2017), it was noted that demographic profiles revealed that out of 44 patients more females than males and more English speaking patients than Spanish felt like they were not included in the plan of care (Appendix E).

Currently, I am working diligently on collecting and comparing pre- and post-implementation data to evaluate outcomes and plan to have this completed by August 15, 2017. I am utilizing evaluation tools such as a nursing competency checklist, results of a nursing satisfaction survey, audits of reportable events and Press Ganey scores to evaluate the success on my project. Sustainability for my CNL project will heavily rely on representing the organization's mission, having a unit champion, perceived benefits of staff and patients, and maintaining stakeholder support. By implementing a standardized BSR tool to improve patient outcomes, increase patient and staff satisfaction, and improve safety, my CNL improvement project aims to represent and uphold Dignity Health's core values of dignity, collaboration, stewardship, justice, and excellence (Dignity Health, 2016). Having a champion will play a critical role in positively influencing others to continue to utilize this method of communication in an effort to maintain successful outcomes.

Furthermore, I anticipate successful project implementation which be reflected by collected benchmarking data. This will gain continued stakeholder support including perceived benefits by patients, staff members, and senior leadership. My project will not only evaluate the quality of BSR performance, but will assess staff and patient experiences in regard to satisfaction in order to further inspire continued use. I plan to post data on the unit to show staff members the anticipated positive results yielded by this project. Currently, night shift nurses are the targeted

population, however, I expect to eventually see standardization of my CNL project BSR tool on all shifts in the microsystem.

One of the biggest challenges I initially faced was gaining staff support and interest. I do find that because I work in the same microsystem in which I am trying to implement a process change, certain staff members were not taking me seriously. However, through consistent modeled behavior to match expectations of my project and storytelling, I have slowly started to gain respect and trust. With that being said, I have learned the value of flexibility and building trusting relationships and through networking, I have gained continued support from senior leadership and the unit director and as a result, I have come to the realization that change is something that takes time, but is possible to achieve. I have learned that being consistently proactive, positive, and resourceful are essential characteristics to possess as a nursing leader. I plan on making an effort to continuously build upon these skills as a future CNL.

I would like to take this opportunity to thank all of the staff members who supported, participated, and contributed to my CNL project during my time spent as a CNL student at WHC. It has been truly a pleasure learning and working with some of the best. A special thanks to my unit manager Susan Gonzalez and my preceptor Julia LeRoux for supporting my educational goals in becoming a Master's prepared professional.

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Appendix A

Bedside Shift Report Tool**Preparation**

- Oncoming RN arrives on time to prepare for report. This means before 0700 or 1900
- Report begins at 0700 or 1900.
- Oncoming RN should bring WOW (Workstation on Wheels) to bedside report to each patient's room.

Introduction

- Off going nurse uses AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank You) to introduce oncoming nurse to patient and family
- Update Whiteboards with correct information
 - Other team members may be present (CNAs, RT, Lab, etc).

Information Exchange

- Use of SBAR (*Situation, Background, Assessment, and Recommendation*)
- Use of simple terms and language that patient and family will understand (including use of interpreter services as needed), avoid using medical terms that patient is unfamiliar with (i.e. NPO).

Patient Involvement

- Give patient and/or family the opportunity to ask questions related to care, clarify exchanged information, review plan of care/ goals for the day including expected hourly rounding.

Safety Scan

- Review the patient, environment, AND EHR (Electronic Health Record) bedside.
 - **Patient Assessment:** Any incisions, wounds, dressings, drains, catheters, IV lines
 - **Environment Assessment:** IV pumps, oxygen, suction equipment, call bell in reach, bed low and locked in position.
 - **EHR:** Review of medication administration record to verify all medications have been given and documented correctly, vital signs, I&Os, etc.

Allow the oncoming RN to verify info and ask questions.

Make sure to update whiteboards with correct name, date, pain schedule, rounding signatures, and plan for the day.

RNs will preserve confidentiality by discussing confidential information at the nurses' station outside of the patient room.

Use nursing judgment to assess individual patient needs (for example, some patients do not like to be woken up for rounds-discuss expectations ahead of time).

Set the next shift up for success (Refill empty IV fluids, PCA's, administer pain medication, etc.)

Appendix B

Quantitative Cost Analysis Reportable Events

Reportable Events	Absorbed Costs by the Organization
<u>Kinked Foley Catheter</u>	<ul style="list-style-type: none"> • Laboratory Testing= \$500 • Extended LOS x1= \$4,000 <p>Total= \$4,500</p>
<u>Patient Fall due to Bed Alarm</u>	<ul style="list-style-type: none"> • X-ray of Hip = \$500 • PT evaluation= \$200 • Pain Medication= \$500 • Extended LOS x1= \$4,000 <p>Total= \$5,200</p>
<u>Hypoglycemic Episode (G-tube feeding)</u>	<ul style="list-style-type: none"> • Laboratory Testing= \$500 • Hypoglycemic Medications= \$800 • Extended LOS x3= \$12,000 <p>Total= \$13,300</p>
<p>Total amount of unnecessary costs to WHC due to these three events alone</p> <p style="text-align: center;">\$23, 000</p>	
<p>\$0 costs to implement BSR tool</p>	<p>WHC Financial Savings</p> <p style="text-align: center;">\$23,000</p>

Appendix C

Nursing Satisfaction Survey: Bedside Report Tool

Dear Med-Surg Nurses,

In an effort to optimize patient safety, improve patient and staff satisfaction, and reduce the number of communication related errors during shift report, the medical-surgical unit at WHC will be implementing the utilization of a standardized bedside report tool as part of our daily routine. It is important for us to know how this process impacts your nursing practice. We will be asking for your feedback at regular intervals and will use the information to evaluate our progress and to consider making adjustments.

Please take a few moments to complete the following survey. The survey is anonymous and should take about 5 minutes. Thank you for your feedback!

1. Shift

- Days-8
- Days-12
- Nights-8
- Nights-12

2. Please select a response to the following:

	Agree	Disagree	Neutral
Report time is adequate.			
Report gives me pertinent information.			
Patient condition matches information given in report.			
Report fosters good interpersonal relationships between shifts.			
Report promotes good communication with patients and families.			
Satisfied with shift-to-shift report			

3. In your opinion, what are some reasons shift report is not performed at the bedside?

Appendix D

BEDSIDE REPORT TOOL COMPETENCY CHECKLIST

Name: _____

Title: _____ Unit: _____

Skills Validation			
Method of Evaluation:	DO-Direct Observation	VR-Verbal Response	WE-Written Exam OT-Other
QUALITY BEDSIDE REPORT	Method of Evaluation	Initials	Comments
<u>PREPARATION</u>			
Bedside report begins on time (promptly at or before 0700/1900)			
<u>INTRODUCTION</u>			
Off going nurse uses <u>AIDET</u> (Acknowledge, Introduce, Duration, Explanation, and Thank You) to introduce oncoming nurse to patient and family			
Whiteboard is updated with correct information (date, names, plan of care, goals, etc.)			
<u>INFORMATION EXCHANGE</u>			
Nurse uses proper demonstration of SBAR (Situation, Background, Assessment, and Recommendation)			
Use of simple terms and language that patient and family will understand (including use of interpreter services as needed), avoid using medical terms that patient is unfamiliar with (i.e. NPO).			
WOW (Workstation on Wheels) present during bedside report and utilized to clarify any information.			
<u>PATIENT INVOLVEMENT</u>			
Nurse gives the patient and/or the family the opportunity to ask questions related to care, clarify exchanged information, review plan of care/ goals for the day including expected hourly rounding.			
<u>SAFETY SCAN</u>			
Nurse reviews the patient, environment, AND EHR (Electronic Health Record) bedside.			

Nurse performs patient assessment: visually inspecting all incisions, wounds, dressings, drains, catheters, and IV lines			
Nurse performs environmental assessment: visually inspecting IV pumps, oxygen, bed alarms, and suction equipment present. Making sure call bell and personal belongings are within reach, bed low and locked in position.			
Nurse performs EHR Assessment: review of medication administration record to verify all medications have been given and documented correctly, vital signs, I&Os, etc.			

Name of Person Validating the Skills: _____

Signature of Skills Validator: _____ Date: _____

I received a copy of the Standardized Bedside Report Tool.
I understand the importance of utilizing a Standardized Bedside Report Tool and my role in preserving patient safety.
I agree with this competency assessment.
I will contact my supervisor, manager or director if I require additional training in the future.

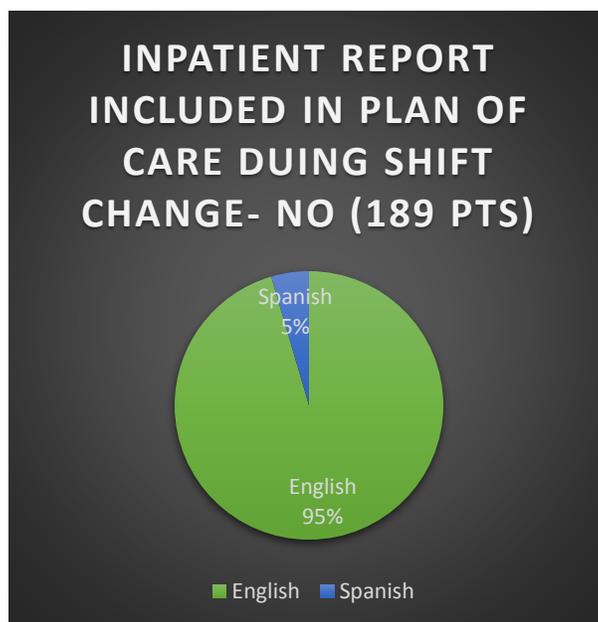
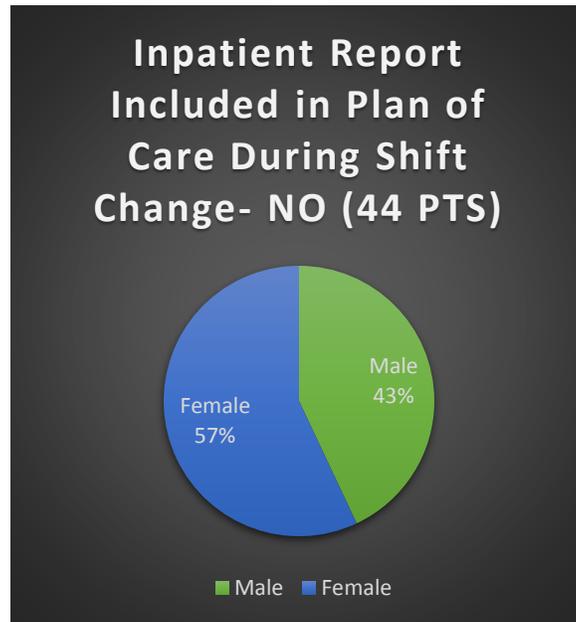
Employee Signature: _____ Date: _____

Appendix E

Press Ganey Scores

Demographic Profile- Pre- Implementation Data

During shift change did nurses included you in the plan of care?



Appendix F

Gantt Chart

