

Re-Standardization of Bedside Shift Report in an Acute Inpatient Rehabilitation Facility

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Abstract

Problem: The lack of consistency in bedside shift report (BSR) in a 42-bed acute inpatient rehabilitation hospital (IRH) has contributed to a decrease in patient experience scores, specifically patient participation at shift change. Data indicated the 52% goal for including patients during change of shift report was not consistently met. Best evidence supports 68% patient involvement in BSR. The aim of this 15-week quality improvement project was to increase nurse adherence with the current BSR, policy, and to improve scores for patient inclusion during shift change. **Method:** Pre-implementation surveys were emailed to staff about their perceptions of BSR. The survey consisted of 10 questions with a Likert response format ranging from 1 to 5 with 1 being strongly disagree and 5 being strongly agree. Education on BSR was provided using a checklist from the Agency for Healthcare Research and Quality (AHRQ, 2017). Audits were done by direct observation. **Results:** Out of N=48, nurses, 79% (n=38) did the pre-implementation survey and 81%(n=39) were educated on BSR; 38% (n=18) complemented the post-implementation survey. For pre-implementation survey results, 82%(n=31) nurses strongly agreed that BSR promotes patient involvement in care and 29%(n=11) strongly agreed to practicing BSR regularly. For post-implementation survey, 95%(n=17) strongly agreed that BSR promotes patient involvement in care and 56% (n=10) strongly agreed to practicing BSR regularly. A total of 224 encounters were observed in 15 weeks; 75% (n=168) took place at the bedside. Out of the 168 encounters that took place by the bedside, 74% (n=124), included the patient in BSR. The facility's Process measure scores for patient inclusion in BSR showed an average increase from 39%, four months pre-implementation to 60% four months post-implementation. **Conclusion:** Re-standardization of BSR improved nurse adherence and patient inclusion at shift change report.

Re-Standardization of Bedside Shift Report in an Acute Inpatient Rehabilitation

According to the Agency for Healthcare Research and Quality (AHRQ, 2017), studies have shown when patients are involved in their care, it can lead to considerable improvements in safety and quality of care. In addition, communication in the presence of the patient fosters trust and strengthens patient provider relationships, thereby enhancing communication, and clinician satisfaction. According to The Joint Commission (2006, as cited in Friesen, White, & Byers, 2008), a national patient safety goal was established that required organizations to standardize hand-off approaches and encouraged active patient participation in the process. One way for nurses to involve patients in their care, is to carry out BSR. Adherence with BSR has been a problem in a 42 bed inpatient rehabilitation hospital (IRH). Despite the policy to carry out report by the bedside, nurses continued to perform report at the nursing station. The goal for patient inclusion at shift change was 52%, but data indicated nurses were not including patients during change of shift report. The IRH target goal of 52% had not been met consistently which was concerning, because best evidence supports 68%. To determine the severity and origin of the problem, a root cause analysis was performed. The primary factor identified was the nursing staff's perception of bedside reporting as time consuming. Additionally, there was a noticeable gap in nurses' evidence-based understanding of BSR and its correct execution. Further complications included extraneous interruptions during BSR, specifically from family members and call light activations. Patient-related preferences also posed barriers to effective BSR implementation; for instance, some patients preferred not to be disturbed during sleep and many lacked awareness of the significance of BSR. Lastly, there was a lack of continuous management practices and accountability in leadership. Refer to Figure 1 for fish bone diagram to further explain challenges with BSR. The aim of this quality improvement project was to increase nurse

adherence with the current BSR policy, and to improve patient experience scores, specifically on patient participation at shift change. This was executed by setting new standards, re-educating staff, and then assessing adherence to the new standard.

Available Knowledge

An evidence review was conducted to evaluate the effectiveness of BSR on patient and clinician satisfaction. Seven studies were selected to justify this practice change, as noted in Table 1. According to evidence synthesis, Scheidenhelm et al. (2017), Walsh et al. (2018), and Mardis et al. (2016) concluded that BSR improves patient satisfaction. Whitty et al. (2017) compared nurses' and patients' preferences for BSR and found that both groups favored bedside handover, with patients showing a stronger preference for this practice. Bresson et al. (2019) indicated that patients are receptive to BSR to participate in their care and be at the forefront of nursing care. Ford et al. (2020) focused on the timing and content of BSR, concluding that it occurs efficiently with substantial information exchange and meaningful nurse-patient interactions. Lastly, Jimmerson et al. (2021) explored nurses' and supervisors' perceptions of BSR; their findings showed that while nurses considered environmental assessment critical during BSR, supervisors did not view it as important. Overall, all studies support BSR as a means of involving patients in their care, thus enhancing patient satisfaction. See Table 2 for evidence synthesis.

Rationale

The Framework chosen for this project is the Promoting Action on Research Implementation in Health Services (PARiHS) framework. Refer to Figure 2 for framework. The main concepts of this framework include evidence, context, and facilitation (Kitson et al., 1998). The PARiHS framework is a multidimensional framework which was established to overtly

challenge the main path for conceptualization of implementation (Bergström et al., 2020). This framework was selected because it puts emphasis on the necessity for proper facilitation to improve the probability of success. With this framework, the needs of the organization define the type of facilitation and the role and skill of the facilitator. (Kitson et al., 1998). The PARIHS framework accurately incorporates the difficulties of BSR. It also examines the elements which can act as barriers to implementing BSR. According to Kitson et al. (1998), with this framework, successful implementation occurs when the evidence is scientifically strong and aligns with professional consensus and target population. Furthermore, the context must be open to change with supportive cultures, strong leadership, and appropriate monitoring and feedback procedures.

Methods

Context

An Organizational Readiness to Change Assessment (ORCA) tool was utilized to evaluate the facility's readiness for change. The ORCA tool aids in assessing an organization's readiness to adopt evidence-based practices, as detailed by Helfrich et al. (2009). This instrument operates based on concepts from the PARIHS framework and has the following Cronbach reliabilities for its subscales: evidence (0.74), context (0.85), and facilitation (0.95) (Helfrich et al., 2009). The ORCA tool determined the facility's readiness for change. The results revealed that the domain of staff culture scored the lowest (13/20), indicating resistance to change. To mitigate this barrier, the use of champions is recommended since the domain of clinical project champion scored high (18/20). According to a study by Bonawitz et al. (2020), champions exhibit attributes such as influence, ownership, physical presence during the initiation of the initiative, persuasiveness, and leadership skills, all of which contribute to the project's success. These attributes also enable champions to build and control professional networks, create

momentum for change, establish a positive learning environment, ensure an easy workflow, and engage key stakeholders (Bonawitz et al., 2020). Readiness for change based on opinions of the organization's leaders scored high (17/20), with leadership supporting changes in practice patterns to improve patient care. Anticipated barriers included high nurse to patient ratio which is 1: 6 or 1:7, staff shortages, and staff resistance to change. A coalition of stakeholders was created to implement the practice change. Refer to Table 3 for Stake holders. The team established Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) goals to ensure successful implementation of this project. Structure goals included creating a BSR checklist. Process outcomes aimed for 100% nurse adherence to BSR and 100% patient participation in BSR.

Intervention

Re-standardization of BSR occurred over a 15-week period. Refer to Table 4 for the Gantt Chart. The first week of the implementation process began on August 28th – September 3rd. Prior to starting, an email was sent out to nurses on the unit to introduce the initiative. The first part of the implementation process involved distributing a pre-implementation survey to staff to determine their perceptions of BSR. The survey consisted of 10 questions with a Likert response format ranging from 1 to 5 with 1 being strongly disagree and 5 being strongly agree. For details on the survey questions, see Appendix B. The responses from this survey guided the provision of education. Nurses were assured that their responses were anonymous, and that participation was voluntary. Two assistant nurse managers (ANMs) were selected as champions for the project. The project lead (PL), who was the student, initiated educational sessions in the first week of implementation.

A checklist from AHRQ was used to highlight the elements required to complete BSR. Critical elements emphasized during the educational sessions included introducing the incoming nursing staff to the patient and family and inviting them to participate in the report. This was followed by opening the electronic health records on the computer in the patient's room to conduct a verbal SBAR (Situation, Background, Assessment, Recommendation) report, using words that the patient and family could understand. Next, a focused safety assessment of the patient and the room was conducted. The final step involved reviewing tasks to be completed and identifying the patient and family's needs and concerns. For the BSR checklist and proposed process map, refer to Appendix C and Figure 4, respectively. The effectiveness of education was assessed through a quiz, with questions available in Appendix D. A minimum of two and a maximum of five nurses were educated each shift. The quiz results showed that nurses understood the importance and critical aspects of BSR, with scores ranging from 90% to 100%.

To ensure the success of the intervention, the ABCDE framework was employed to identify strategies and tactics for project implementation, as outlined by Powell et al. (2015). Strategies included identifying champions and early adopters. In addition, lunch was provided when goals or milestones were achieved, and personalized "thank you" cards were distributed to staff. Consistent performance in BSR was recognized via emails that included the manager. Lastly, updates on the progress of the initiative and discussions on barriers were shared with staff during daily huddles. Refer to Table 7 for detailed implementation strategies.

Measures

Measures for this project involved comparing pre- and post- implementation results to assess changes in nurses' attitudes towards BSR following the initiative. The process goals and outcomes were quantified using specific ratios, which provided numerators and denominators to

calculate the percentages for these measures. Process outcomes included nurse adherence to BSR and patient inclusion in BSR. In addition to direct observation, patient inclusion in BSR was also monitored monthly, through the IRH patient experience tableau. The outcome of patient inclusion at shift change consisted of one of the questions on the e-survey sent to patients after they are discharged from the facility. The project utilized exploratory measures, given that the hospital employs tools like the Press Ganey survey to evaluate the impact of patient engagement during shift changes. Structural changes for this initiative involved the use of the AHRQ bedside checklist to facilitate bedside reporting.

Data collection was carried out by the PL and commenced in the second week of the initiative, following the educational sessions. BSR auditing was conducted weekly through direct observation by the PL, who utilized a modified AHRQ checklist as the audit tool to examine each encounter. Details of the BSR audit tool are available in Appendix A. Encounters were directly entered in real time into the audit tool in the Research Electronic Data Capture (REDCap). Audits were conducted weekly, and the audit day was selected randomly each week. Audit days were selected randomly to observe different nurses; audits were performed for both morning and evening change of shift.

Ethical Considerations

The project received a Non-human Subjects Research determination from the Human Research Protections Office (HRPO) of the University of Maryland School of Medicine (UMSOM) and the host facility's Institutional Review Boards (IRB). All data collected for this initiative were gathered using instruments in REDCap, a secure, password-protected, and HIPAA-compliant server. Access to this server was limited exclusively to the PL and project

faculty. In addition, data collection for this initiative did not contain any patient identifiers or personal health information.

Results and Analytics

Out of 48 nurses on the unit, 79% (n=38) participated in the pre-implementation survey. The pre-implementation results revealed that 82%(n=31) of nurses strongly agreed that BSR promotes patient involvement in care, and 29%(n=11) strongly agreed to practicing BSR regularly. Of the same group, 81%(n=39) were educated on BSR, but only 38% (n=18) complemented the post-implementation survey. The post- implementation survey revealed that 95%(n=17) of nurses strongly agreed that BSR promotes patient involvement in care and 56% (n=10) strongly agreed to practicing BSR regularly. Refer to Tables 8 and 9 for survey results. Over 15 weeks, a total of 224 handoff encounters were observed, averaging 15 observations a week, with 75% (n=168) of the encounters occurring at the bedside. Of the bedside encounters, 74% (n=124), included the patient in BSR. The IRH monthly process measure scores for patient inclusion in BSR showed an average increase from 39%, four months pre-implementation to 60% four months post-implementation.

Run charts were used to analyze the data collected throughout the implementation process. The run chart used for the analysis produced 15 data points throughout the weeks of implementation as data were entered on a weekly basis. By creating a run chart and marking the points at which interventions occurred, it was possible to determine whether an intervention influenced the outcome in question (McQuillan et al., 2016). The run chart for the process outcome of carrying out BSR did not show any shift, trends, or runs. See Figure 5 for the BSR run chart. The run chart for BSR showed a spike in week one with 83% of nurses performing BSR, likely due to high initial motivation. In week two, BSR adherence dropped from 83% to

50%. This decline was primarily because most patients were asleep during the morning shift change and thus unable to participate. This issue was addressed by sending an email reminding nurses to inform patients about BSR the night before. There was also a drop from 77% in week seven to 71% in week eight; this drop could be attributed to the high volume of COVID-19 patients in the facility that week. A further drop to 59% occurred in week nine, possibly due to the involvement of float nurses who did not work regularly on the unit, hence, were unfamiliar with the BSR process. To address this, monthly emails were sent out to all nurses about the BSR process.

The process outcome of patient inclusion at shift change, in week one, showed that only 41% of BSR encounters included the patient. After reinforcing the importance of including patients during daily huddles, a positive change was noted, with inclusion rates rising to 50% and 62% in weeks two and three, respectively. A noticeable spike to 69% occurred in week seven, potentially boosted by thank-you cards and emails. However, this was followed by a drop back to 41% in week eight, mainly due to language barriers as there were six non-English-speaking patients at the facility at the time. Although this barrier was addressed with the nurses, they reported that using interpreter services to engage with the patient during BSR was time-consuming during shift changes. Refer to Figure 6 for the run chart on patient inclusion at shift change.

Discussion

The goal of this quality improvement project was to enhance nurse adherence to BSR using a bedside report checklist, while actively including patients during shift change report. The primary findings from the initiative show an overall improvement in patient inclusion at shift change. Although not all nurses were fully compliant with the BSR protocol, responses to both

the pre- and post-implementation surveys recognized that performing BSR actively involves patients in their care.

Looking at the results of the initiative, it can be postulated that there is a correlation between the implemented interventions and the observed outcomes. The utilization of champions was particularly effective; these individuals facilitated communication across organizational levels, demonstrated enthusiasm, and drove the implementation process forward. Their participation indicated a strong belief in the initiative's value and a commitment to its success, which was well-received and respected by their colleagues. Additionally, the project findings underscore the importance of positive reinforcement as a significant motivator for nurse adherence to BSR. According to Huston (2024), positive reinforcement bolsters workers' resolve, whereas constant negative feedback can be perceived as punitive and may lead to diminished performance. During this project, acts of recognition, such as sending emails that highlighted nurses consistent with BSR practices and included the manager, played a crucial role in fostering adherence and showing appreciation.

The project also observed a positive trend in Press Ganey scores within the domain of nursing care, suggesting an increase in patient experience satisfaction. This aligns with findings from previous studies by Scheidenhelm et al. (2017), Walsh et al. (2018), and Mardis et al. (2016), which indicated that BSR can significantly improve patient satisfaction. Although other factors could also contribute to high patient satisfaction scores, BSR forms a critical part of the process measures used to measure this outcome. The use of a BSR checklist proved vital in reminding nurses of the essential components of BSR, consistent with evidence from Scheidenhelm et al. (2017), who found that a BSR competency checklist effectively trained nurses and yielded positive results. Furthermore, BSR aligns with evidence suggesting that

during the handover process, patients can offer valuable insights by providing information and asking questions.

However, the project faced several limitations. A surge in COVID-19 presented challenges in performing BSR, as nurses found it time-consuming to don and doff personal protective equipment within the brief windows available for report. Additionally, the smaller number of participants in the post-implementation survey compared to the pre-implementation survey could have skewed the results. Lastly, the IRH data on monthly patient inclusion at shift change are indicative of the specific time of data collection, given that e-surveys are available to patients for approximately two months after discharge.

The sustainability of BSR can be enhanced by incorporating information about BSR into the patient admission binder, maintaining ongoing communication, and continually evaluating to determine when reinforcement is needed. Additionally, including the BSR checklist in the orientation binder for new nurses at the time of their orientation is essential.

Conclusion

BSR is beneficial to both patients and nurses. Patients benefit from BSR by listening to the report and learning their plan of care and goals. Furthermore, the BSR process recognizes the patient as a participant in the care process hence, reassuring the patient that their care is a collaborative and team effort. In addition, being part of the change of shift report decreases patient and family anxiety and improves patient satisfaction. BSR also improves clinician satisfaction; it can enhance teamwork as it provides the occasion for nurses to collaborate at the bedside thus, facilitating accountability and quality care. Furthermore, BSR facilitates communication and aids the incoming nurse to prioritize patients according to what they learned during BSR about patient needs. One of the strengths of this quality improvement project was the

robust support from leadership. Discussion with management to incorporate information on BSR in patient admission binder will help inform patients about the bedside shift report process, hence, enabling spread and sustainability. Information on BSR can be in the form of a brochure with hospital name and logo and consisting of information about the process of BSR, its importance, and what to expect. Furthermore, based on the findings of this initiative, there is a potential adaptability of a BSR intervention to different settings and cultures. Such a replication in other facilities would facilitate spread. Overall, BSR can help achieve positive outcomes such as staff accountability, enhanced communication, patient and family satisfaction, nursing quality, and patient safety.

Future projects should consider measuring the time spent on BSR, as nurses find it to be time consuming, especially when patient request toileting or other immediate needs during report. Addressing these immediate needs can delay the completion of BSR thus, affecting its efficacy. Future initiatives could involve patient care technicians into nurse's BSR, streamlining the process to make it more time efficient while ensuring patient's needs are promptly met.

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discrete choice experiment. *Health Expectations*, 20(4), 742–750.

<https://doi.org/10.1111/hex.12513>

Table 1*Evidence Review Table*

Citation: Scheidenhelm, S., & Reitz, O. E. (2017). Hardwiring bedside shift report. <i>The Journal of Nursing Administration</i> , 47(3), 147–153. https://doi-org.proxy-hs.researchport.umd.edu/10.1097/NNA.0000000000000457						Level: II (John Hopkins level of evidence).
Purpose/ Hypothesis	Type of Evidence Research Design	Sample – Population, Size, Setting	Intervention Procedures	Primary Outcome/Measures	Results/Conclusions	
<p>The purpose of this project was to increase nurse compliance with bedside report and increase patient satisfaction scores.</p>	<p>Quasi-experimental</p>	<p>Sample: N=132 nurses' pre-implementation (n=73 M/S) and (n=59 OB), N=202 nurses 1 month post implementation (n=147M/S, n=55OB), and 147nurses at 3months (n = 94 M/S, n = 53 OB). Number of patients 4 months before implementation 197 patient's M/S, n=93 OB, 4 months post implementation n=190 M/S and n=99 OB. Setting: 149-bed community hospital in the 46-bed medical/surgical (M/S) unit and 12-bed obstetrics (OB) unit. Population: Nurses and patients in med surge and OB units</p>	<p>Simulations of bedside report and assigned an electronic learning module on the facility's educational system to nurses on both units. Tools from the Studer Group Toolkits in a packet was given to each nurse. The toolkit included a detailed process on how to conduct bedside report, the SBAR format for the report, a patient letter describing the process for them, and a bedside handoff competency checklist. The team also used a simulation of bedside report and competency tool to check nurse's adherence to the standardized process. Bedside competency was measured for 2 weeks and 1 and 2 months postimplementation.</p> <p>The Press Ganey and HCAHPS Instruments were used to measure patient satisfaction</p>	<p>Primary Outcomes included bedside compliance results and Patient satisfaction outcomes. Outcomes measured under patient satisfaction included the following statements. "Nurses kept you informed," "staff included you in decisions regarding treatment," "communication with nurses" "nurses explained in a way you understand."</p>	<p>Comparison of nurse compliance with bedside report, as observed through random observations, improved at 1 month on both units. Pre-implementation observations indicated the nurses complied with bedside report, 12% (M/S) and 55% (OB). Post-implementation nurses complied with the process for 85% (M/S) and 84% (OB) at 1 month and 84% (M/S) and 90.6% (OB).</p> <p>Patient Satisfaction score results M/S unit "nurses kept you informed" [the mean score of the pre implementation was lower (mean [SD], 89.95 [15.99]) than the mean (SD) of the</p>	

				<p>postimplementation (92.74 [12.84]) but was not statistically significant ($t = -1.89, P = .059$). “Staff included you in decisions regarding treatment, “also had no significant differences between the means ($t = -1.359, P = .175$) of the 2 groups. For “communication with nurses” domain, the % of always increased from 79.6 to 86.8, and percentile rank increased from 52 to 99. For the question of “nurses explained in a way you understand” the mean (SD) score improved from 92.22 (14.79) to 94.3 (11.54) but was not significant ($t = -1.158, P = .248$). The percentage of always responses increased from 75.2 to 81.0, and percentile rank increased from 43 to 94.</p> <p>Obstetrics: “Nurses kept you informed” was not statistically significant ($t = 0.129, P = .897$). Although the mean (SD) improved from the pre-implementation group (94.26 [13.95]) to the postimplementation group (95.51 [9.32]).</p> <p>“Staff included you in decisions regarding treatment, also had no significant differences between the means ($t = -$</p>
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					<p>0.736, P = .463) of the 2 groups. For the “communication with nurses “domain, the percentage of “always” increased from 90.6 to 96. For the statement “nurses explained in a way you understand,” the mean (SD) score decreased slightly from 97.8 (7.12) to 97.55 (8.34) but was not significant (t = 0.216, P = .829). The percentage of “always” responses also decreased from 92.1 to 91.9.</p> <p>Conclusion: A change management strategy and standardized approach to bedside report helped increase nurse compliance with the process, leading to improved patient Satisfaction.</p>
<p>Whitty, J. A., Spinks, J., Bucknall, T., Tobiano, G., & Chaboyer, W. (2017). Patient and nurse preferences for implementation of bedside handover: Do they agree? Findings from a discrete choice experiment. <i>Health Expectations</i>,20(4), 742–750. https://doi.org/10.1111/hex.12513</p>					<p>Level: II (John Hopkins level of evidence).</p>
Purpose/ Hypothesis	Type of Evidence Research Design	Sample – Population, Size, Setting	Intervention Procedures	Primary Outcome/Measures	Results/Conclusions
<p>To describe and compare patients’ and nurses’ preferences for the implementation of bedside handover.</p>	<p>Experimental</p>	<p>Sample: Half of patients were female, and they had been in hospital for a median of 5 days prior to survey completion. Nurses were a median age of 33 years and most</p>	<p>In the DCE, participants were asked to make six (patients) or nine (nurses) choices between two different bedside handover alternatives, a third option of “I will like handover away from my bedside” was also included. in each choice set for both groups, enabling participants to “opt out “of</p>	<p>The main outcomes were:</p> <ul style="list-style-type: none"> • Preferences for handover at the bedside. • Preferences for the characteristics of bedside handover. This was further categorized 	<p>Both patient and nurse participants preferred handover at the bedside rather than elsewhere however, this was mores strongly the case for patients (handover at the bedside chosen for</p>

		<p>(89.0%) were female. Nurses had worked in the profession for a median of 6 years and 39% had supervisory responsibility for other staff, with 11.5% being a charge nurse.</p> <p>Size: A total of 486 patients and 205 nurses provided consent and began the survey, of which 401 patients and 200 nurses completed the data,</p> <p>Population: Adult medical patients (age ≥ 18 years) were eligible providing they had sufficient English language skills to complete the survey and had been admitted at least 2 days prior to recruitment, to ensure they had experienced bedside handover. Registered and enrolled nurses working on the same medical wards were eligible to participate. No casual nurses were recruited.</p> <p>Setting: Medical wards across two Australian hospitals Hospital 1 was a 750-bed public hospital in the state of Queensland, whilst Hospital 2 was a 500-bed private hospital in Victoria.</p>	<p>bedside handover, if they preferred. The wording for nurse and patient set were similar with minor changes in pronouns. The attributes and levels were developed based on semi-structured interviews carried out with 20 medical patients and 20 nurses to get their perceptions of patient participation in bedside handover and an expert consensus group.</p>	<p>into patient and nurse preferences, comparison of patient and nurse preferences, variation in preferences for the characteristics of handover across participants</p> <p>Instrument: The mixed multinomial logit regression of the choice data. Was used to measure the outcomes.</p>	<p>2350 (97.7%) choice sets for patients and 1652 (91.8%) choice sets for nurses; Mann-Whitney U-test, $P < .001$).</p> <p>Conclusion: The authors concluded that there is a strong support that nurses and patients prefer handover at the bedside. It also indicates strong support for inviting patients to actively engage in two-way information exchanges. This may indicate that further work needs to be undertaken on the way patients are invited to participate in handover as this is strongly preferred by patients.</p>
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<p>Forde, M. F., Coffey, A., & Hegarty, J. (2020). Bedside handover at the change of nursing shift: A mixed-methods study. <i>Journal of Clinical Nursing</i>, 29(19–20), 3731–3742. https://doi-org.proxy-hs.researchport.umd.edu/10.1111/jocn.15403</p>					<p>Level: III (John Hopkins level of evidence).</p>
Purpose/ Hypothesis	Type of Evidence Research Design	Sample – Population, Size, Setting	Intervention Procedures	Primary Outcome/Measures	Results/Conclusions
<p>To describe the structures, processes, and content of bedside handover at the change of nursing shift in an acute-care context.</p>	<p>Qualitative Data</p>	<p>Sample: Purposeful sampling strategy Size: N=30 episodes of nursing handover Setting: The study was conducted in Ireland, in a private acute-care 345 bedded hospital, and incorporated six diverse clinical areas, encompassing both medical and surgical wards.</p>	<p>Thirty episodes of bedside handover were simultaneously audio-recorded and observed using a researcher-developed tool modelled on the five domains of the British Medical Association's Safe Handover–Safe Patients framework. The audio recordings were analyzed using content analysis. Quantitative and qualitative data generated were then triangulated to develop a more complete interpretation of the structure, process, and content of information transferred at the patient's bedside during the change of nursing shift. The study followed Good Reporting of Mixed Methods Study guidelines</p>	<p>Outcomes included.</p> <ul style="list-style-type: none"> • The process of handover [How]. • The content of handover audio recordings [What] • Qualitative analysis of the audio recordings of the handovers. • The style of delivery [How the information was handed over]. • The type of information exchanged during bedside handover [What was handed over]. • Interactions during bedside handover [Who was interacting during the handover and how they completed the handover]. 	<p>Results: Bedside handover was observed to be mainly conducted at a fast pace. However, within these timeframes large volumes of complex information were shared. and important nurse–patient interactions occurred. Analysis of the audio recordings provided evidence that the dialogue during handover was nurse-dominated and the outgoing nurse appeared to influence the degree of patient participation. Conclusion: Bedside handover at the change of nursing shift involves three key stakeholders: outgoing nurse, incoming nurse, and the patient. A combination of intricate communication skills both verbal and nonverbal facilitates the rapid sharing of large volumes of complex information which is necessary for the continuity and safety of</p>

					patient care across nursing shifts
<p>Bresson, V., Cadorin, L., Stevanin, S., & Palese, A. (2019). Patients' experiences of bedside handover: findings from a meta-synthesis. <i>Scandinavian Journal of Caring, Sciences</i>, 33(3)556–568. https://doi.org/10.1111/scs.12673</p>					<p>Level: III</p> <p>(John Hopkins level of evidence).</p>
Purpose/ Hypothesis	Type of Evidence Research Design	Sample – Population, Size, Setting	Intervention Procedures	Primary Outcome/Measures	Results/Conclusions
<p>The aim of study was to obtain a deeper understanding of the experiences of patients regarding bedside shift reports.</p>	<p>A systematic qualitative study</p>	<p>Sample included primary qualitative studies, studies which explored the perceptions and experiences of adult (>18 years) patients regarding BSR(s), studies published in English and lastly, studies with abstracts available. Moreover, qualitative data from mixed-</p>	<p>Four databases were systematically explored (PubMed, CINAHL, Scopus and PsycINFO) without any limitation in time and up to the 31 August 2018.</p>	<p>Three major outcomes emerged from the selected studies in patient experiences when involved in hospital BSRs: the first theme is being involved the 2nd is being the center of nursing care processes and the 3rd is experiencing life-threatening issues. These main themes were further divided into subthemes.</p>	<p>The results revealed that Patients are supportive of bedside shift reports as a right, as an occasion to be involved in their care, and to be in the center of the nursing care process.</p> <p>The researchers concluded that little has been studied on bedside shift reports experience from the perspective of patients. According to the findings, implementation of the BSR should include providing education to nurses about the preferences and expectations of patients, as well as the critical issues that they can experience during the bedside shift reports.</p>

Walsh, J., Messmer, P. R., Hetzler, K., O'Brien, D. J., & Winningham, B. A. (2018). Standardizing the bedside report to promote nurse accountability and work effectiveness. <i>Journal of Continuing Education in Nursing</i> , 49(10), 460–466. https://doi-org.proxy-hs.researchport.umd.edu/10.3928/00220124-20180918-06					Level: III (John Hopkins level of evidence).
Purpose/ Hypothesis	Type of Evidence Research Design	Sample – Population, Size, Setting	Intervention Procedures	Primary Outcome/Measures	Results/Conclusions
The aim was to examine the effects of an educational learning activity on bedside handoff reporting related to accountability and work effectiveness.	Single group pretest–posttest design	Sample: A convenience sample. Eligible RNs were full or part time, regardless of job title, spending all their time in direct patient care. Non- direct care nurses were excluded from this intervention. Population: The sample was ethnically diverse, with the majority being Latino. (Pretest, 55.8%; posttest, 60.3%) Participants consisted of 75% women and 25% men both pretest and posttest. Size: N=184 RNs 104 nurses (representing most of the nurses working in the two units) completed the pretest, with only 73 of those completing the post- test. Setting: 250-bed south Florida Hospital on two medical–surgical units participated	A demographic questionnaire, the Specht and Ramler Accountability Index-Individual Referent and the Conditions for Workplace Effectiveness Questionnaire-II were administered pre–post educational (learning activity) intervention. Of 184 RNs, 104 completed the pretest, with only 73 of those completing the posttest. Instruments used: Specht and Ramler Accountability Index (SRAI). The SRAI measures individual nurse accountability and provides a tool for measurement of a concept recognized as an important facet of professional nursing practice. Conditions for Workplace Effectiveness Questionnaire-I and -II. (CWEQ). Consists of CWEQ-I and CWEQ- II, which measure the concept of structural empowerment, seen as a measurement of workplace culture.	Following completion of the educational intervention, the following outcomes were measured (a) improve accountability in practice, (b) increase effectiveness in practice, (c) increase job activities and satisfaction, and (d) improve communication and organizational relationships.	There were statistically significant differences in all subscale mean ranks: global empowerment, with the pretest lower than the posttest (pretest M=23.00, n=95; posttest M=24.98,n=63,z= -3.32, p = .00); work effectiveness (opportunity, information, support, and resources), with pretest significantly lower than the posttest (pretest M = 46.30, n = 104; posttest M = 52.00, n = 73, z = -4.75, p = .00); organizational relationships and communication, with pretest significantly lower than the posttest (pretest M = 16.00, n = 104; posttest M = 18.00, n = 73, z = -5.14, p = .00); nurse job activities and satisfaction with pretest significantly lower than the posttest (pretest M = 12.00, n = 104; posttest M = 13.00, n = 73, z = -4.51, p = .00). The study results indicated no statistical that difference between the pretest and the posttest of

					<p>accountability (pretest M = 3.17, n = 90; posttest M = 3.17, n = 71, z = -.44, p = .65).</p> <p>Conclusion: For medical-surgical units, incorporating bedside reporting can increase nurse satisfaction, accountability, and positive outcomes.</p>
<p>Citation: Mardis, T., Mardis, M., Davis, J., Justice, M.E., Holdinsky, R.S., Donnelly, J., Ragozine- Bush, H., & Riesenber, A.L. (2016). Bedside shift-to-shift handoffs: A systematic review of the Literature <i>Journal of Nursing Care Quality</i>.31(1), 54–60. https://doi.org/10.1097/NCQ.000000000000142</p>					<p>Level: III</p> <p>(John Hopkins level of evidence).</p>
Purpose/ Hypothesis	Type of Evidence Research Design	Sample – Population, Size, Setting	Intervention Procedures	Primary Outcome/Measures	Results/Conclusions
To verify the impact of a bedside shift-to-shift handoff on patients and providers.	Systematic Review of qualitative studies	Sample: N= 41 articles. With inclusion criteria involving shift handoffs by any health care professional, and could either be quantitative or qualitative research data, and concentrated specifically on bed- side handoffs. Articles that were not handoff specific were excluded.	An iterative process was used by trained reviewers to create an abstraction form designed to verify final suitability for full review, assess article characteristics, and remove data pertinent to the study in question.	1) self-report measures which involved asking health care providers and patients to report on their attitudes, beliefs, perceptions, and satisfaction. The 2 nd outcome involved methods used to evaluate activities conducted by health care providers and the third outcome involves evaluating or assessing actual patient outcomes i.e., patient’s condition or response to care.	Most studies used self-report measures; 18 (44%) staff, 20 (49%) patients, 1 (2%) family and 1 (2%) parent (for pediatric patients) indicated improved satisfaction or perceptions with bedside hand- offs. Four (10%) reported perceived better patient care, and 1 (2%) fewer patient complaints related to shift-to-shift handoff periods. There was a moderate amount of process outcomes reported including 6 (15%) articles indicating decreased time spent in handoff, 5 (12%) decreased over- time

					<p>hours or related costs, 1 (2%) decreased call light activations and decreased call light response time, and 1 (2%) decreased call light usage during shift change.</p> <p>The researchers concluded that Bedside handoff is a potential solution to many of the communication errors associated with shift-to-shift handoffs.</p>
<p>Jimmerson, J., Wright P, Cowan, P., King-Jones T, Beverly, J., & Curran G. (2021) Bedside shift report: Nurses opinions based on their experiences. <i>Nursing Open</i>, 8(3).1393-1405. doi: 10.1002/nop2.755.</p>					<p>Level: III</p> <p>(John Hopkins level of evidence).</p>
Purpose/ Hypothesis	Type of Evidence Research Design	Sample – Population, Size, Setting	Intervention Procedures	Primary Outcome/Measures	Results/Conclusions
<p>To identify and describe acute care clinical nurses' and nursing supervisors' experiences and opinions regarding: process of BSR, appropriate content for BSR and barriers and facilitators related to implementation of BSR.</p>	<p>A qualitative study</p>	<p>Setting: acute care 500 bed, not-for-profit academic medical center located in the southern United States.</p> <p>Sample size: Clinical nurses ($N = 22$) and nursing supervisors ($N = 12$). Inclusion criteria for clinical nurses included (a) age 18 years or older; (b) registered nurse who spent 50% or more of their work time delivering direct patient</p>	<p>Clinical nurses and nursing supervisors from every inpatient division were recruited and interviewed. The data were analyzed for relationships, similarities, and differences. Themes were then identified by two independent researchers.</p>	<p>Five themes were identified: (a) time constraints and clinical nurse's workflow must be taken into consideration; (b) a modified approach is necessary; (c) process and specific critical content should be individualized so that it is meaningful for all parties involved; (d) specific critical content that should be discussed outside the patient's room; and (e) specific critical content that should be discussed</p>	<p>Although most critical content identified by nursing supervisor and clinical nurse participants was similar, there were a couple of differences. For example, 32% of clinical nurse participants ($N = 7$) reported that assessing the environment was important while nursing supervisors failed to include it as a critical component of BSR. In addition, 33% of nursing supervisors ($N = 4$) reported that discharge plans were important, but</p>

		<p>care; (c) were currently working on an acute adult care inpatient unit at the medical center; and (d) had experienced/attempted BSR. Exclusion criteria consisted of nurses who had not completed employee orientation or were in a supervisory position.</p> <p>Inclusion criteria for Supervisors included (a) 18 years of age or older, (b) currently supervising one of the medical center's acute care adult inpatients units and (c) had experienced/attempted implementing BSR.</p> <p>Exclusion criteria consisted of supervisors who had been in a supervisory position at the medical center for less than 1 year</p>			<p>it was not mentioned by clinical nurse participants.</p> <p>The researchers concluded that one way to minimize interruptions is to conduct BSR using a modified approach, where a portion of the hand-off occurs inside and outside the patient's room. In addition, this study identified the nurses' preferred location where specific critical topics should be discussed.</p>
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Table 2*Evidence Synthesis Table*

Project Title: Re-standardization of Bedside Shift Report in an Acute Inpatient Rehabilitation Facility			
JHNEBP Model Level	Total Number of Sources	Author and Quality Rating of each study	Synthesis of Findings
Level I Experimental study · Randomized Controlled Trial (RCT) · Systematic review of RCTs with or without meta-analysis			
Level II Quasi-experimental studies · Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis	2	B- Scheidenhelm et al, 2017, & Whitty et al 2017 B	Whitty et al 2017 study showed that patients strongly supported handover at the bedside and both patient and nurses preferred patients to be invited to participate rather than not invited. Also, they indicated that patients desire being updated on their care while hearing information being handed over, as well as contributing to the handover by adding information and asking questions. Scheidenhelm et al, 2017 did not show a significant difference in the domain of if staff included the patient in decisions regarding treatment. Whitty et al 2017, recommended that bedside handover should be tailored to the choice of each individual patient.
Level III Non-experimental study · Systematic review of a combination of RCTs, quasi-experimental, and non-experimental studies, or non-experimental studies only, with or without meta-analysis · Qualitative study or systematic review of qualitative studies with or without meta-synthesis	5	Forde et al 2020, Bresson et al 2019, Walsh et al 2018, Mardis et al 2016, Jimmerson et al 2021 B-	Forde et al 2020, Bresson et al 2019, Walsh et al 2018, Mardis et al 2016, Jimmerson et al 2021 focused more on the effectiveness of BSR on nurse's accountability and work effectiveness. Mardis et al 2016, showed an increase in staff and patient satisfaction after the implementation of bedside shift report. Jimmerson et al 2021, focused on the barriers and facilitators of practicing BSR and concluded that one way to minimize interruptions is to conduct BSR using a modified approach, where a portion of the hand-off occurs inside and outside the patient's room. Furthermore, they indicated the need to individualize the critical content discussed to ensure it is helpful and meaningful for the nurses, patient, and family.

<p>Level IV Opinion of respected authorities and/or reports of nationally recognized expert committees/consensus panels based on scientific evidence</p>			
<p>Level V Evidence obtained from literature reviews, quality improvement, program evaluation, financial evaluation, or case reports · Opinion of nationally recognized expert(s) based on experiential evidence</p>			
<p>Overall Quality Rating w/rational and Recommendation:</p> <p>B- Overall, the evidence indicates good and consistent evidence and practice change. However, due to the small sample size of most of the studies except for Whitty, et al 2017, the validity could be affected. Also, the generalizability of the findings in most of the hospitals is limited by use of convenience samples with data collection from single hospitals.</p> <p>Based on the. Synthesis it can be recommended that future studies be carried out in multiple locations in order demonstrate generalizability.</p>			

Table 3

Members involved in implementation of BSR.

Team Member /Title	Responsibilities
<p>1. Student Project Lead DNP-FNP Student</p>	<p>Will lead the planning, implementation, analysis, and evaluation of the project (student will provide education, create checklists, and collect and analyze data)</p>
<p>2. Assistant Nurse Manager Clinical Site Representative</p>	<p>Clinical site representative will assist student in developing a proposal for the project, facilitate the IRB process, and provide guidance and support in putting together an implementation team.</p>
<p>3. Nurse Manager Sponsor</p>	<p>Project sponsor will secure resources and remove barriers encountered by the nurse practitioner student during the implementation of the project</p>

4. All Assistant Nurse Managers both day and night shift	Project champions
5. Admission nurse	Inform patients upon admission about BSR.
6. Project Faculty	Provide guidance on the project's planning, implementation, and evaluation

Table 4
Structure and Process Goals for the Implementation of BSR

Project Structure Goal(s)	Project Process Goal(s)	Outcome Goal(s)
1. A checklist on how to carry out BSR will be placed on the unit before implementation.	1. 100% of Nurses will be trained on the techniques of how to carry out BSR. 2. Nurses' awareness of the importance of BSR will be improved compared to the baseline data. (pre-implementation survey compared with post-implementation survey)	1. 100% of patients will be included during BSR by 15 weeks. 2. 100% of nurses will be compliant with BSR by 15 weeks.

Table 5

Gantt Chart

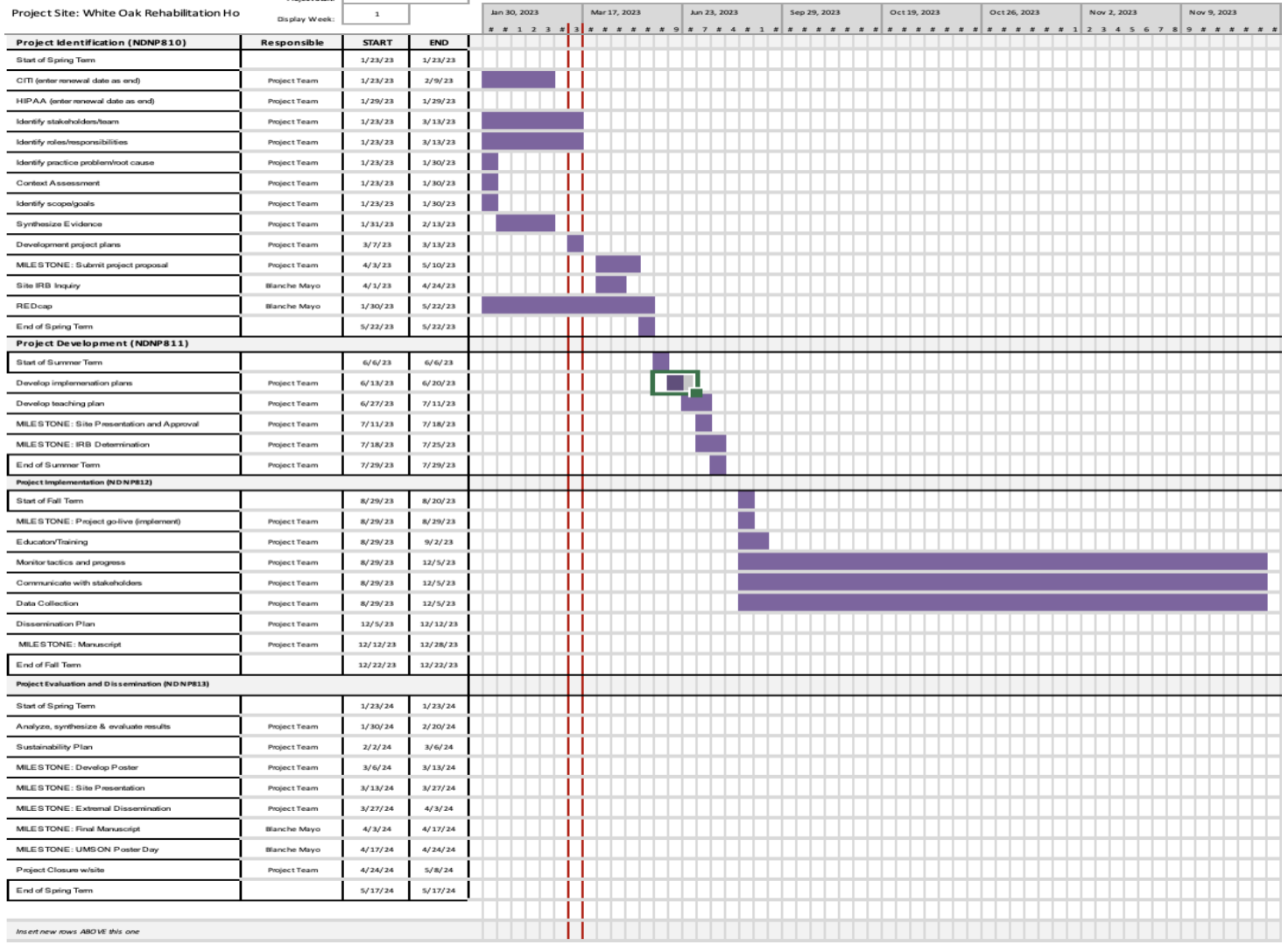
DNP Project Title: Re- standardization of Bedside shift Report in an Inpatient Rehabilitation Hospital

Blanche Mayo

Project Start: Tue, 1/31/2023

Project Site: White Oak Rehabilitation Ho

Display Week: 1



Insert new rows ABOVE this one

Table 6

Measure for implementation of BSR

Measures		
Project Goals	Measure Pre-Implementation	Measure During Implementation
Structure Goals		
checklist on how to carry out BSR will be provided to staff on the unit before implementation	Check list available to staff. “Yes” or “No”	Data not needed during implementation
Process Goal(s)		
3. 100% of Nurses will be trained on the techniques of how to carry out BSR appropriately. 4. Nurses’ awareness of the importance of BSR will be improved compared to the baseline data.	1. Numerator: Number of nurses who received report on bedside shift training. 2. Denominator: Total number of nurses on unit Pre-implementation survey results	1. Numerator: Number of nurses who received report on bedside shift training. 2. Denominator: Total number of nurses Post-implementation survey results
Outcome Goal(s)		
100 % of patients on the unit will participate in BSR. 100% of nurses will be compliant with BSR.	Data 3 months pre-implementation through patient experience tableau Measurement not needed pre-implementation.	Data tracked monthly for 3 months post-implementation through patient experience tableau. 1. Numerator: Number of encounters observed by the bedside 2. Denominator: Total number of Encounters observed

Table 7*Implementation Action Table*

Strategy	Tactics	Rational	Monitoring
Accountability: Provide Performance Reviews (Powell, et al., 2015)	One on one meetings will be held between assistant nurse managers and staff who are not carrying out new initiative to discuss how current behavior does or does not meet expectations of job performance.	Address appropriate behavior and expectations for job performance	This strategy will be monitored with the evaluation of the number of one-on-one meetings with staff nurses. The success of this method will be confirmed with a decrease of such meetings
Buy-In: Provide Incentives (Powell, et al., 2015)	Provide professional recognition, a certificate of achievement, for early adopters, a thank you email that cc's their manager and can be put into their employee file, provision of breakfast and luncheon when the group achieve pre-determined milestones.	Helps encourage good practice and discourage staff from reverting to old habits	Strategy will be monitored at how frequently staff achieves pre-determined milestones.
Collaboration: Identify and prepare Champion (Powell et al., 2015)	1 assistant Nurse manager (ANM) for day and 1 for night will be selected as champions. Early adopters will also be selected as superusers	the use of champions demonstrates attributes such as influence, proprietorship, physical presence during initiation of initiative persuasiveness, and leadership skills which promotes success of the project (Bonawitz et al., 2020)	Achieves adherence to behavioral standards that support agreed-upon code of conduct practices supported by a nonpunitive culture and zero-tolerance policy.
Communication: Remind Clinicians (Powell, et al. 2015)	Communication with patients and staff through daily huddles to enhance uptake and adherence.	helps identify barriers for patients and nurses to participate in BSR and develop strategies to overcome these barriers	Strategy will be monitored by staff adherence to initiative
Data: complete audits and provide feedback (Powell, et al., 2015)	Audits will be conducted. weekly for 15-week. staff.	Audits and feedback will improve. compliance of the new initiative.	Provision of data reports; key data reports will be summarized, and feedback given to staff
Education: Provide education (Powel et al., 2015)	BSR check list will be provided to staff.	The education session will provide teaching. and expectation of the new initiative. post training quiz will allow staff to ask questions and evaluate understanding.	Strategy will be evaluated by verbal post education quiz

Table 8
Pre- Implementation Survey Results

Question	Total Count (N)	Counts/Frequency
Bedside report is an effective means of communication.	38	Strongly Disagree (0, 0.0%), Disagree (0, 0.0%), Neutral (0, 0.0%), Agree (5, 13.2%), Strongly Agree (33, 86.8%)
Bedside report helps assure accountability between peers	38	Strongly Disagree (0,0.0%), Disagree (0,0.0%), Neutral (0, 0.0%), Agree (9, 23.7%), Strongly Agree (29, 76.3%)
Bedside report gives opportunities for mentoring new staff.	38	Strongly Disagree (0,0.0%), Disagree (0, 0.0%), Neutral (2, 5.3%), Agree (9,23.7%), Strongly Agree (27, 71.1%)
Bedside report promotes patient involvement in care.	38	Strongly Disagree (0,0.0%), Disagree (0,0.0%), Neutral (0, 0.0%), Agree (7, 18.4%), Strongly Agree (31, 81.6%)
Bedside report improves patient safety.	38	Strongly Disagree (0,0.0%), Disagree (0,0.0%), Neutral (1, 2.6%), Agree (11, 28.9%), Strongly Agree (26, 68.4%)
Bedside report helps me feel better informed about my patients.	38	Strongly Disagree (0,0.0%), Disagree (0, 0.0%), Neutral (1, 2.6%), Agree (12, 31.6%), Strongly Agree (25, 65.8%)
Bedside report is completed in a reasonable time.	38	Strongly Disagree (0,0.0%), Disagree (3, 7.9%), Neutral (11, 28.9%), Agree (14, 36.8%), Strongly Agree (10, 26.3%)
I practice bedside report regularly.	38	Strongly Disagree (0,0.0%), Disagree (3, 7.9%), Neutral (3, 7.9%), Agree (21, 55.3%), Strongly Agree (11, 28.9%)
Overall, I like face to face interaction with the patient during bedside reporting.	38	Strongly Disagree (0,0.0%), Disagree (0, 0.0%), Neutral (4, 10.5%), Agree (9, 23.7%), Strongly Agree (25, 65.8%)
I feel as though privacy is an issue with bedside reporting.	38	Strongly Disagree (1, 2.6%), Disagree (7, 18.4%), Neutral (7, 18.4%), Agree (15, 39.5%), Strongly Agree (8, 21.1%)

Table 9*Post- Implementation Survey Results*

Question	Total Count (N)	Counts/Frequency
Bedside report is an effective means of communication.	18	Strongly Disagree (0, 0.0%), Disagree (0, 0.0%), Neutral (0, 0.0%), Agree (3, 16.7%), Strongly Agree (15, 83.3%)
Bedside report helps assure accountability between peers	18	Strongly Disagree (0, 0.0%), Disagree (0, 0.0%), Neutral (0, 0.0%), Agree (3, 16.7%), Strongly Agree (15, 83.3%)
Bedside report gives opportunities for mentoring new staff.	18	Strongly Disagree (0, 0.0%), Disagree (0, 0.0%), Neutral (0, 0.0%), Agree (2, 11.1%), Strongly Agree (16, 88.9%)
Bedside report promotes patient involvement in care.	18	Strongly Disagree (0, 0.0%), Disagree (0, 0.0%), Neutral (0, 0.0%), Agree (1, 5.6%), Strongly Agree (17, 94.4%)
Bedside report improves patient safety.	18	Strongly Disagree (0, 0.0%), Disagree (0, 0.0%), Neutral (0, 0.0%), Agree (3, 16.7%), Strongly Agree (15, 83.3%)
Bedside report helps me feel better informed about my patients.	18	Strongly Disagree (0, 0.0%), Disagree (0, 0.0%), Neutral (0, 0.0%), Agree (2, 11.1%), Strongly Agree (16, 88.9%)
Bedside report is completed in a reasonable time.	18	Strongly Disagree (0, 0.0%), Disagree (1, 5.6%), Neutral (2, 11.1%), Agree (2, 11.1%), Strongly Agree (13, 72.2%)
I practice bedside report regularly.	18	Strongly Disagree (0, 0.0%), Disagree (0, 0.0%), Neutral (0, 0.0%), Agree (8, 44.4%), Strongly Agree (10, 55.6%)
Overall, I like face to face interaction with the patient during bedside reporting.	18	Strongly Disagree (0, 0.0%), Disagree (0, 0.0%), Neutral (0, 0.0%), Agree (5, 27.8%), Strongly Agree (13, 72.2%)
I feel as though privacy is an issue with bedside reporting.	18	Strongly Disagree (0, 0.0%), Disagree (0, 0.0%), Neutral (0, 0.0%), Agree (5, 27.8%), Strongly Agree (13, 72.2%)

Note: Questionnaire source: McGinn, Christine. (2017). Nurses Perceptions of Bedside Reporting on an Intensive Care Unit Following Implementation. Master's Theses, Dissertations, Graduate Research and Major Papers Overview. 180.<https://digitalcommons.ric.edu/etd/180>
<https://doi.org/10.28971/542017MC106>

Figure 1

Root cause Analysis fishbone diagram

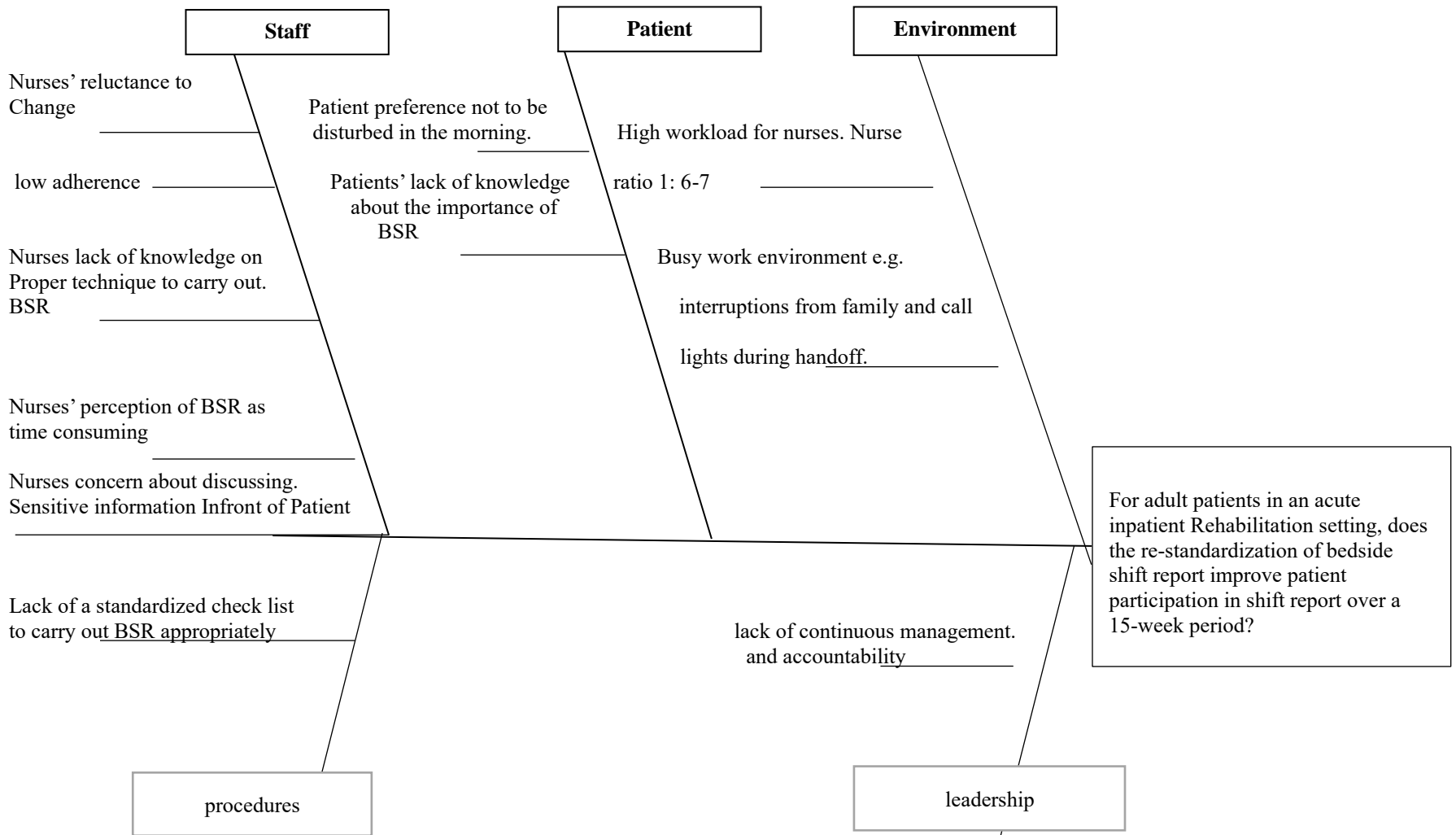
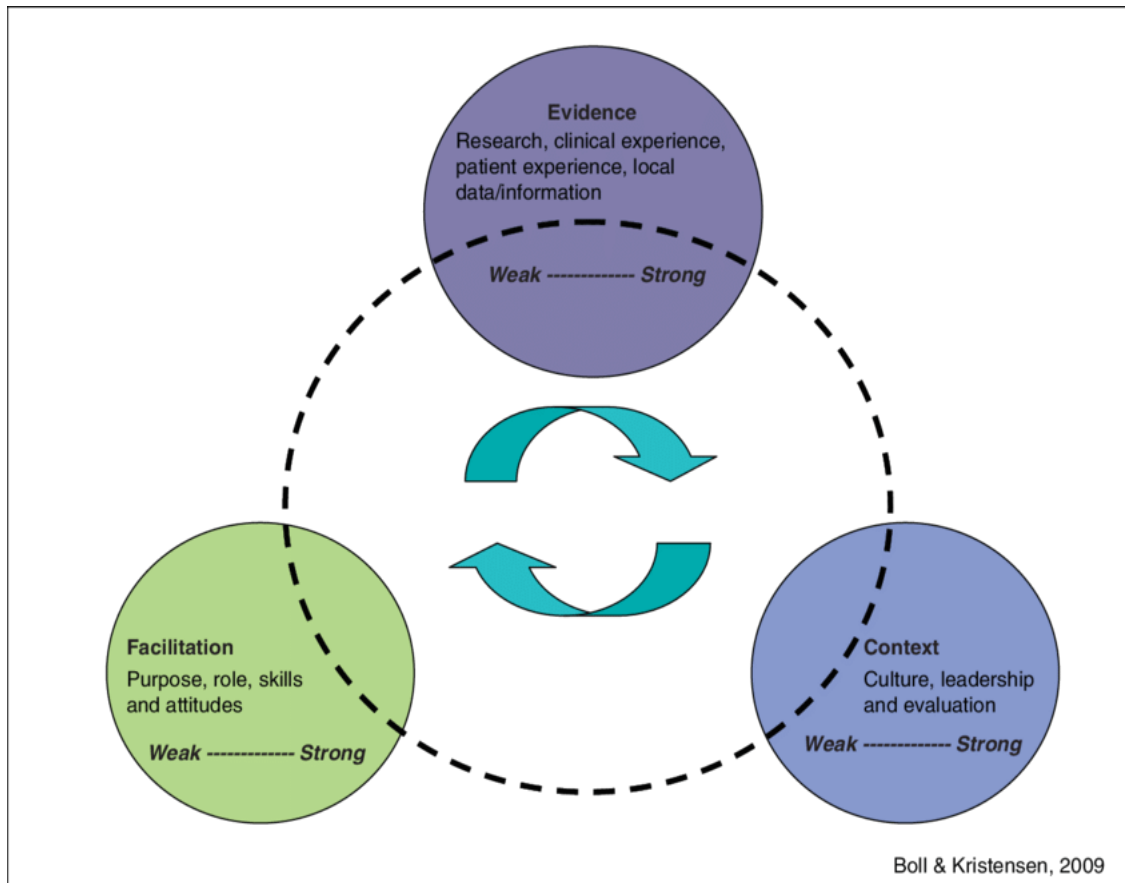


Figure 2

PARiHS framework



Note: Kristenson, H., Borg, T., & Houndsgaard, L. (2012). Aspects affecting occupational therapists' reasoning when implementing research-based evidence in stroke rehabilitation. *Scandinavian Journal of Occupational Therapy*, 19 pp 118–131 DOI: 10.3109/11038128.2011.55619

Figure 3
Current Process Map Bedside Shift Report

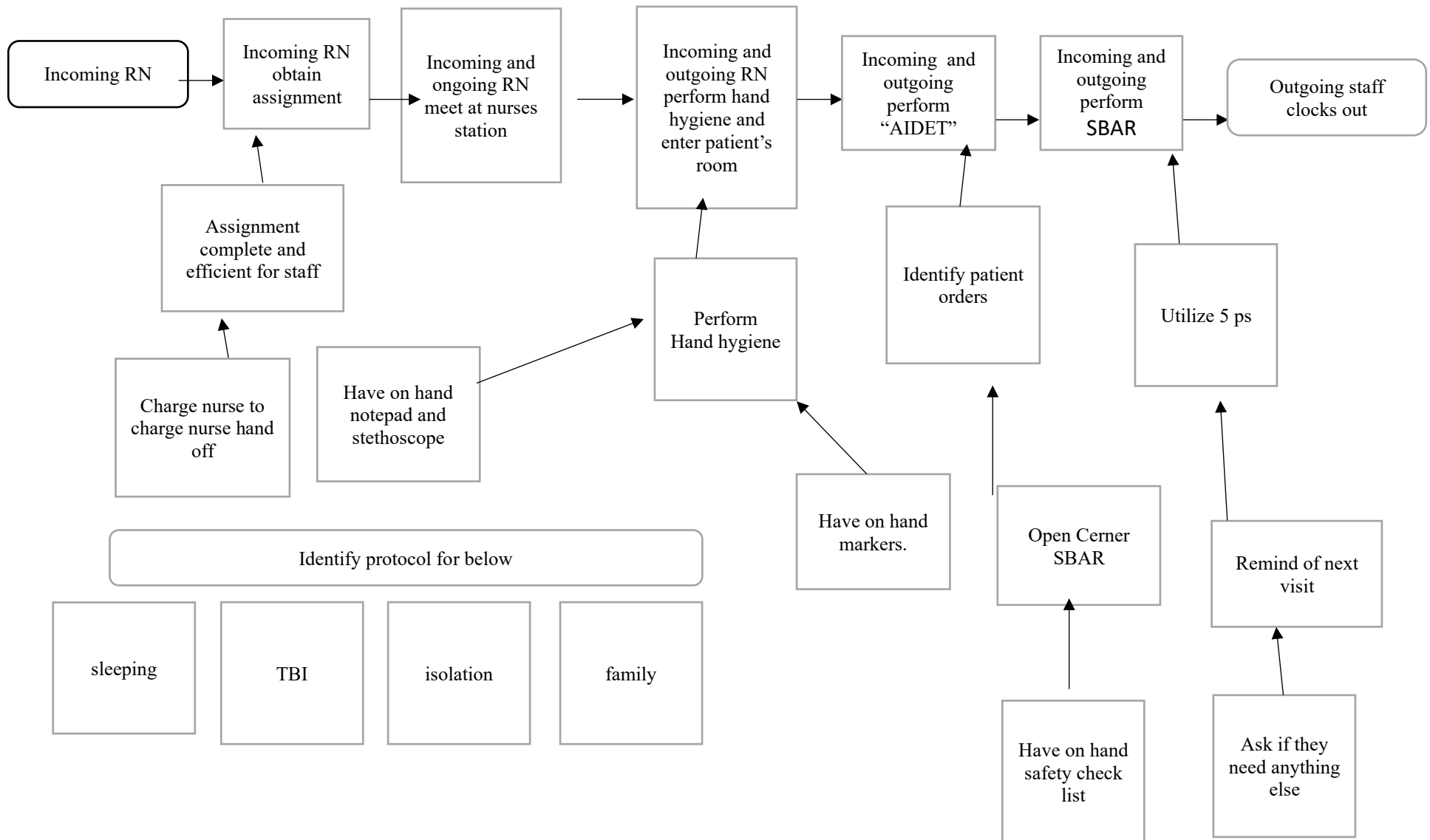


Figure 4

Proposed Process Map Bedside Shift Report

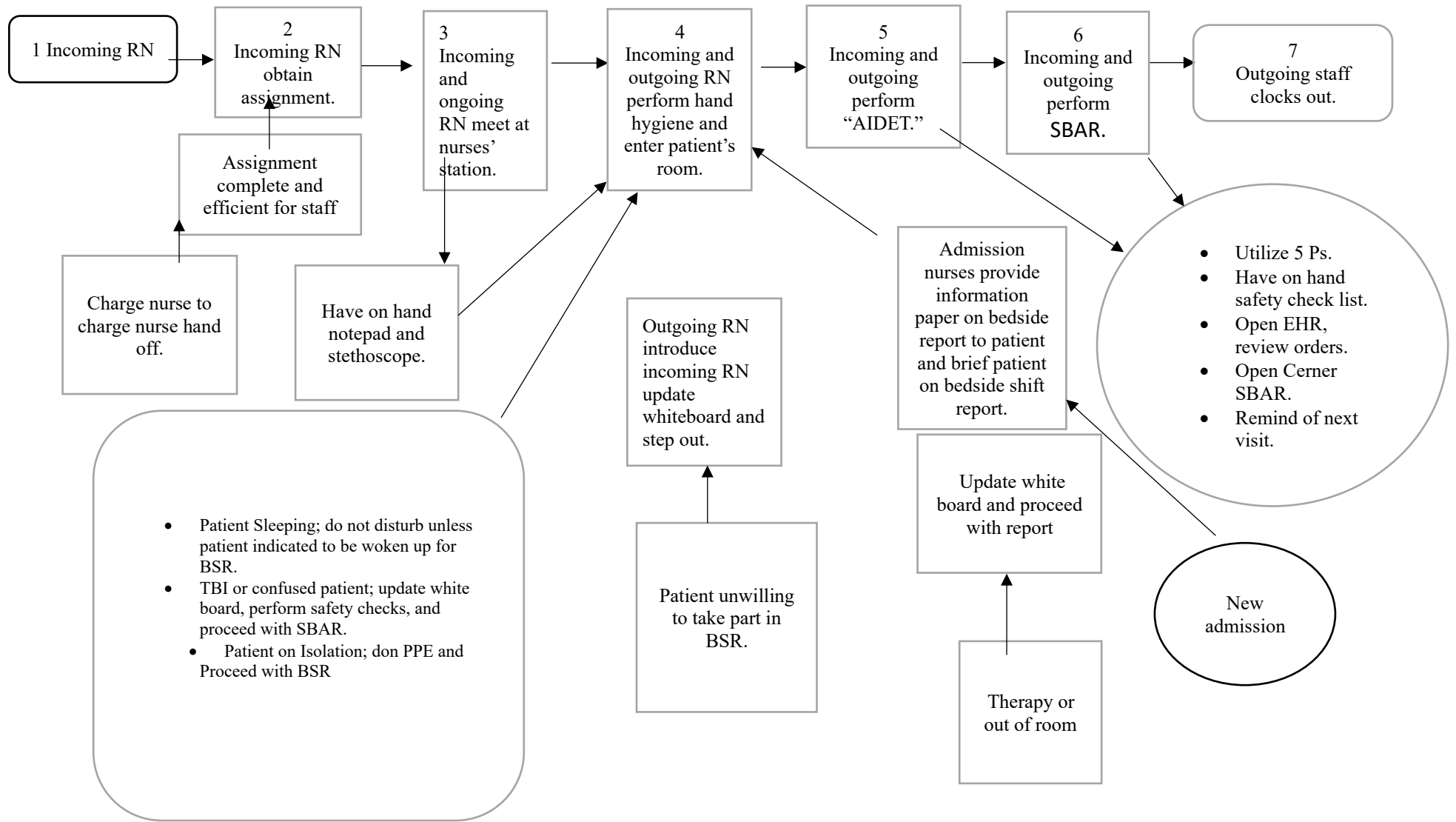


Figure 5

Run Chart for Report Completed at Bedside

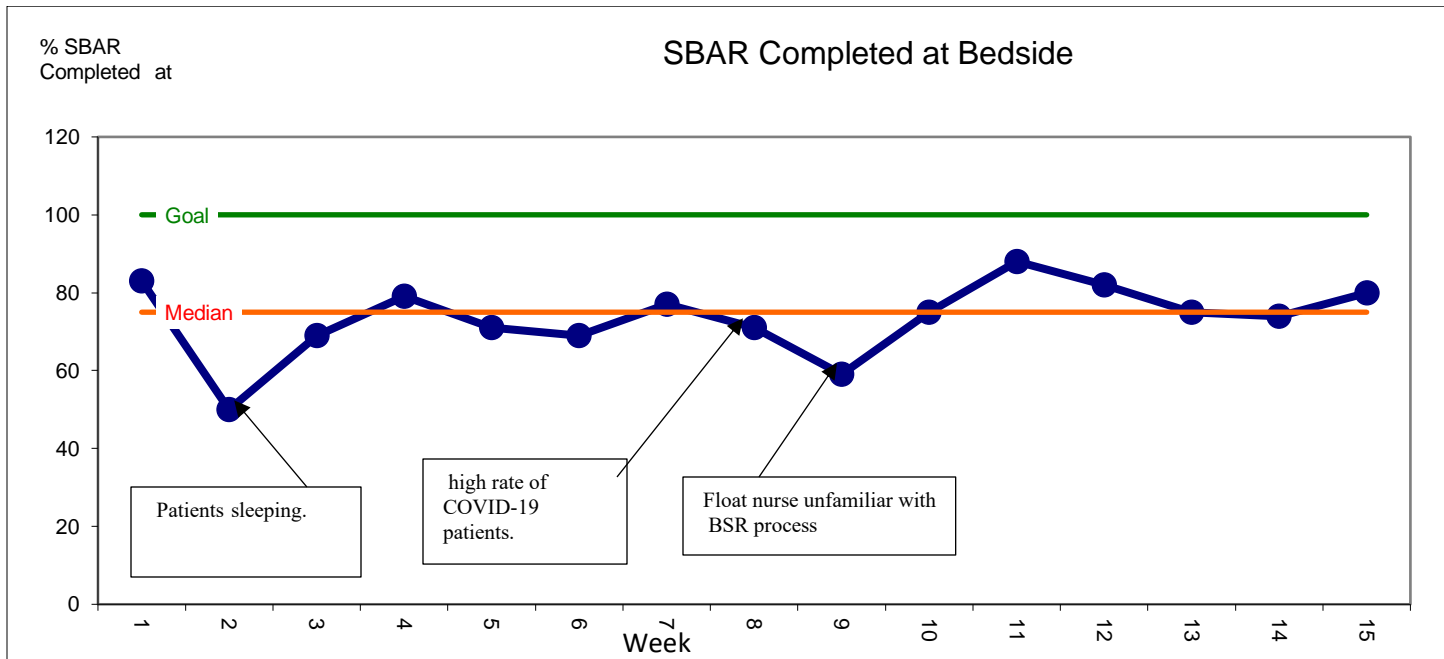
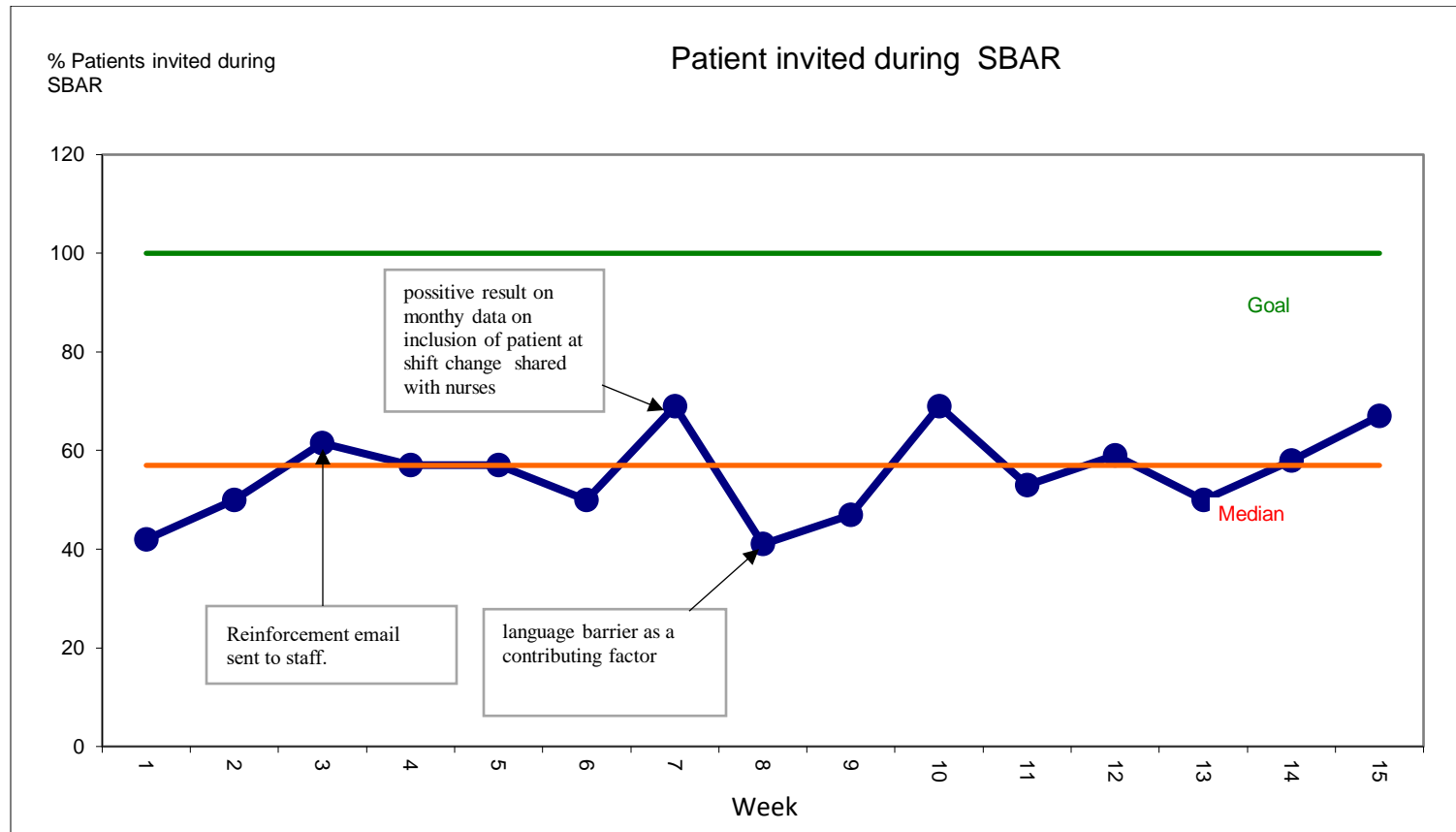


Figure 6

Run chart for patient included at shift change.



Appendix A

RN Bedside Shift Report Audit Tool

Re-standardization of Bed side Shift Report in an Inpatient Rehabilitation Page 1

Bedside Handoff Audit Tool

Study ID	
Week	<input type="radio"/> week 1 <input type="radio"/> week 2 <input type="radio"/> week 3 <input type="radio"/> week 4 <input type="radio"/> week 5 <input type="radio"/> week 6 <input type="radio"/> week 7 <input type="radio"/> week 8 <input type="radio"/> week 9 <input type="radio"/> week 10 <input type="radio"/> week 11 <input type="radio"/> week 12 <input type="radio"/> week 13 <input type="radio"/> week 14
Shift	<input type="radio"/> AM <input type="radio"/> PM
Unit	<input type="radio"/> 6 South <input type="radio"/> 7 South
Knock	<input type="radio"/> Yes <input type="radio"/> No
Hand Hygiene	<input type="radio"/> Yes <input type="radio"/> No
AIDET (Acknowledge, Introduce, Duration, Explanation, Thank you)	<input type="radio"/> Yes <input type="radio"/> No
Invite patient or family member to participate in report	<input type="radio"/> Yes <input type="radio"/> No
SBAR (Situation, Background, assessment, recommendation)	<input type="radio"/> Yes <input type="radio"/> No
Safety Check (Bed/chair alarm and 6 ps [Potty, Position, pain, Pumps, possessions and plenty of time])	<input type="radio"/> Yes <input type="radio"/> No
Update white Board (PCT name and Patient's goal)	<input type="radio"/> Yes <input type="radio"/> No
Ask if patient has any questions	<input type="radio"/> Yes <input type="radio"/> No
Thank patient	<input type="radio"/> Yes <input type="radio"/> No
Perform Hand hygiene	<input type="radio"/> Yes <input type="radio"/> No

Appendix B

RN Pre and Post-Implementation Survey

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RN Bedside Handoff Survey

Please complete the survey below.
Thank you!

1) 1. Bedside report is an effective means of communication Strongly Disagree (1)
 Disagree (2)
 Neutral (3)
 Agree (4)
 Strongly Agree (5)

2) 2. Bedside report helps assure accountability between peers Strongly Disagree (1)
 Disagree (2)
 Neutral (3)
 Agree (4)
 Strongly Agree (5)

3) 3. Bedside report gives opportunities for mentoring new staff Strongly Disagree (1)
 Disagree (2)
 Neutral (3)
 Agree (4)
 Strongly Agree (5)

4) 4. Bedside report promotes patient involvement in care Strongly Disagree (1)
 Disagree (2)
 Neutral (3)
 Agree (4)
 Strongly Agree (5)


5) 5. Bedside report improves patient safety Strongly Disagree (1)
 Disagree (2)
 Neutral (3)
 Agree (4)
 Strongly Agree (5)

6) 6. Bedside report helps me feel better informed about my patients Strongly Disagree (1)
 Disagree (2)
 Neutral (3)
 Agree (4)
 Strongly Agree (5)

7) 7. Bedside report is completed in a reasonable time Strongly Disagree (1)
 Disagree (2)
 Neutral (3)
 Agree (4)
 Strongly Agree (5)

8) 8. I practice bedside report regularly. Strongly Disagree (1)
 Disagree (2)
 Neutral (3)
 Agree (4)
 Strongly Agree (5)

9) 9. Overall, I like face to face interaction with the patient during bedside reporting Strongly Disagree (1)
 Disagree (2)
 Neutral (3)
 Agree (4)
 Strongly Agree (5)

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10) I feel as though privacy is an issue with bedside reporting

Strongly Disagree (1)
 Disagree (2)
 Neutral (3)
 Agree (4)
 Strongly Agree (5)

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Note: McGinn, Christine. (2017). *Nurses Perceptions' of Bedside Reporting on an Intensive Care Unit Following Implementation*. Master's Theses, Dissertations, Graduate Research and Major Papers Overview. 180. <https://digitalcommons.ric.edu/etd/180> <https://doi.org/10.28971/542017MC106>

Appendix C

Agency for Healthcare Research and Quality Checklist



Bedside Shift Report Checklist

- Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report.
- Open the medical record or access the electronic work station in the patient's room.
- Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.
 - S = Situation.** What is going on with the patient? What are the current vital signs?
 - B = Background.** What is the pertinent patient history?
 - A = Assessment.** What is the patient's problem now?
 - R = Recommendation.** What does the patient need?
- Conduct a focused assessment of the patient and a safety assessment of the room.
 - Visually inspect all wounds, incisions, drains, IV sites, IV tubings, catheters, etc.
 - Visually sweep the room for any physical safety concerns.
- Review tasks that need to be done, such as:
 - Labs or tests needed
 - Medications administered
 - Forms that need to be completed (e.g., admission, patient intake, vaccination, allergy review, etc.)
 - Other tasks: _____
- Identify the patient's and family's needs or concerns.
 - Ask the patient and family:
 - o "What could have gone better during the last 12 hours?"
 - o "Tell us how your pain is."
 - o "Tell us how much you walked today."
 - o "Do you have any concerns about safety?"
 - o "Do you have any worries you would like to share?"
 - Ask the patient and family what the goal is for the next shift. This is the patient's goal — not the nursing staff's goal for the patient.
 - o "What do you want to happen during the next 12 hours?"
 - o Follow up to see if the goal was met during the verbal SBAR at the next bedside shift report.

Adapted from the Emory University Bedside Shift Report Bundle.



Appendix D

BSR Post Education quiz

Bedside Shift Report Quiz

Name:

Date:

- 1. Including Patients in bedside shift report (BSR) builds trust in the care process.**
 - a. True
 - b. False
- 2. Some of the benefits of BSR to nurses include:**
 - a. Accountability
 - b. Time management
 - c. Patient safety
 - d. All the above
- 3. All the following are important components of BSR except**
 - a. Introduce the nursing staff, patient, and family.
 - b. Invite the patient and family to participate.
 - c. Conduct a verbal SBAR report with the patient and family, using words they can understand.
 - d. Review tasks that need to be done
 - e. Ignore the patient throughout the report.
- 4. Research shows patient-centered approaches can improve patient safety and patient experience.**
 - a. True
 - b. False