

Bedside Shift Report: A way to improve patient safety

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Abstract

Patient safety is one of the top quality improvement priorities for healthcare organizations. Patient safety affects many aspects of health care including patient satisfaction, sentinel events, and medical errors, as well as hospital reimbursements. Communication is one area that hospitals are diligently improving on to prevent medical error sand sentinel events. Bedside shift report (BSR) is a practice that not only improves patient safety, but it also enhances the quality of care and decreases unnecessary healthcare expenditures. Bedside Shift Report (BSR) is one of the many strategies hospitals around the United States are taking to improve patient safety as well as patient experience and involvement in their care. The purpose of this project is to evaluate the attitudes of nurses after the implementation of bedside shift report at a local hospital in Commerce Township, Michigan. For three weeks, a survey was distributed to nurses at the hospital. The results were collected, interpreted, and suggestions were given to the hospital administrators on how to improve nurses attitudes on BSR. By understanding the nurses' attitudes, hospital administrations will be able to address the barriers and issues that nurses have in participating with bedside shift report.

Chapter 1: Introduction to the health problem

Bedside shift report (BSR) is a practice that not only improves patient safety, but it also enhances the quality of care and decreases unnecessary healthcare expenditures. Bedside Shift Report (BSR) is one of the many strategies hospitals around the United States are taking to improve patient safety as well as patient experience and involvement in their care. Not only is bedside shift report an evidence-based practice, but it is also seen to improve patient satisfaction scores, specifically on the topic of "communicating with nurses." The purpose of this project is to evaluate the attitudes of nurses after the implementation of bedside shift report at a local hospital in Commerce Township, Michigan. Also, this report will evaluate the implementation of BSR using a Logic Model. The capstone project will give an introduction to the importance of bedside shift report and patient safety, describe its significance to public health, explain the methodology of the performed project, discuss the expected outcomes, explain the impact and potential benefits to the hospital, and finally, address several public health competencies.

Patient Safety

Patient safety is a vital issue in all aspects of healthcare. From a CEO's decision to actively participate in daily Gemba roundings on the units, to an environmental service housekeeper using bleach to wipe down a room that was previously occupied by a patient with *Clostridium difficile*, everyone in healthcare has an important role to play to improve patient safety. According to Womack (2011), "Gemba walks denote the action of going to see the actual process, understand the work, ask questions, and learn." The executive members of the hospitals perform these walks. Expert Answers, a magazine that focuses on safety and quality, state that Gemba Walks "are about getting out of your office chair and observing the actual process,

talking with the operators, asking questions and understanding the nature of the work” (Expert Answers, 2015). Each day, the leadership team would perform Gemba Walks on several nursing units. The walks would include at least two executive leaders and the nurse manager, or operational manager. The manager would give a description of what is currently working on the unit, not working, and what efforts are being made to fix the problem. Traditionally, problem-solving takes place in the meeting rooms. Gemba Walks help the decision makers of the hospitals gain a comprehensive understanding of the situation, thus enabling a more thorough solution. This method of lean management is being translated into the medical community as a way to improve the quality of patient care.

Medical Errors

Patient safety is directly affected by medical errors. In 1999, the Institute of Medicine (IOM) published a report called *To Err is Human: Building a Safe Health System*. In their introductory chapter, Kohn, Corrigan, Donaldson, and Molla (1999) discuss some of the statistical significance of medical errors. According to data collected from several hospitals in Colorado, Utah, and New York, between 44,000 to 98,000 Americans die annually due to medical errors (Kohn, Corrigan, Donaldson, & Molla, 1999, p. 1). The lower estimated number (44,000) still exceeds other major causes of death such as motor vehicle accidents (43,458), breast cancer (42,297), and AIDs (16,516) (Kohn, Corrigan, Donaldson, & Molla, 1999, p. 1). A more recent publication in 2016 from the British Medical Journal (BMJ) reported that the mean rate of death from medical errors is 251,454 every year. The researchers calculated this number “using the studies reported since the 1999 IOM report and extrapolating to the total number of US hospital admissions in 2013” (Makary & Daniel, 2016). When comparing this number to the CDC’s ranking of death, medical errors stands as the third most common death in the United

States annually (Makary & Daniel, 2016). Many healthcare providers have challenged this ranking, but this does not excuse the fact that medical errors affect patient safety.

Communication errors

Ineffective communication between healthcare providers is one of the major causes of medical errors. The Joint Commission in 2012 stated that “Ineffective hand-off communication is recognized as a critical patient safety problem in health care; in fact, an estimated 80% of serious medical errors involve miscommunication between caregivers during the transfer of patients” (Joint Commission Center for Transforming Healthcare, 2012). Finally, nursing bedside shift report addresses all strategies of the 2017 Patient Safety Goals provided by the Joint Commission (Joint Commission, 2017). Bedside shift report not only provides nurses the opportunity to assess their patient with a colleague visually but it also directly includes patients in the discussion of their care. In a study performed by Sand-Jecklin and Sherman as cited by Gregory, Tan, Tilrico, Edwardson, and Gamm (2014), it was found that “Patient falls at shift change and medication errors were reduced” (p. 543). BSR has been shown to improve patient safety and led to a reduction in adverse patient events such as falls (Gregory et al., 2014, p. 543).

Medical and communication errors have a huge impact on patient safety every day. By reducing these preventable errors, healthcare organizations can improve patient safety, decrease excess healthcare costs, and improve patient satisfaction scores. Bedside shift report is one of the many ways that medical and communication errors can be reduced.

In this project, the hospital’s management sought to make a quality improvement in patient safety as well as create a better patient-centered environment. Based on numerous evidenced-based studies, they decided that there needed to be a change in the way nurses practice and communicate with each other and their patients. The results of the direct observations on the

nursing units were that nurses were not performing bedside shift report. As mentioned, several nursing barriers on BSR that were discovered from the internship's direct observations were receiving patient report from too many nurses, interruptions due to patient needs, patient confidentiality breaches, waking up the sleeping patient, and overall a negative attitude about change was revealed.

Chapter 2: Literature review

Definition of Public Health

Many intellectual individuals have defined Public Health in their way. However E. L. Bishop in 1928 gave a definition that is relevant to this topic:

“Public health practice is the organized effort of society to eliminate disease, elevate the standard of health and well-being and increase the span of life. Its scope of activity deals, not only with the causes and conditions of disease, but with the causes and conditions of health as well. In dealing with the causes and conditions of disease, activity must be essentially preventive in character, whereas in dealing with the causes and conditions of health activity must be productive of such causes and condition” (American Journal of Public Health, 1928).

This definition is significant to this project because it explains how tertiary care organizations can be directly involved in the improvement the public’s health at a primary level. Traditionally, hospitals are considered tertiary prevention in public health. The tertiary level of prevention works to “retrain, re-educate and rehabilitate people who have already developed an impairment or disability” (Three levels of health promotion/disease prevention). This is contrary to the primary level of prevention, the gold standard of public health, which takes preemptive measures that prevent the onset of illness or injury before the disease process begins.

Patient safety in the hospital is a public health issue. This topic has multiple implications for the public, for health care providers, medical expenses, and healthcare reimbursement. Bedside shift report is one method that affects all aspects of patient safety. The Agency for Healthcare Research and Quality (AHRQ) reports that bedside shift report is beneficial to all

patients because it improves these four important areas: Patient safety and quality, Patient experience of care, Nursing staff satisfaction, and Time management and accountability between nurses (AHRQ, 2013). The first two areas (Patient safety and quality and the Patient experience of care) are important and directly impact public health. In regards to patient safety, for example, one study noted by the AHRQ (2013) “found that more than 70 percent of adverse events are caused by breakdowns in communication among caregivers and between caregivers and patients.” Another study “showed a decrease in patient falls during the change of shift, dropping from one to two patient falls per month to one patient fall in six months” (AHRQ, 2013). The safety measures that are seen in bedside shift report not only decrease the amount of excess expense in healthcare, but they also reduce sentinel events and comorbidities. Bedside shift report also increases the patient-nurse relationship as reported by several hospitals that implemented BSR (AHRQ, 2013).

Patient safety significance to the public

In the study called *Patient Safety: This is Public Health*, Card (2014) made the case that “all healthcare-associated harm (not just healthcare-associated infections) is a population health issue” (p. 6). Similarly to the *To Err is Human: Building a Safe Health System* study, this study reports a high number of deaths that are related to “preventable adverse events” in the hospital setting. This study does not only focus on deaths due to medical errors, but it also observes “serious harm” which is “harm that led to an extended hospital stay, permanent harm, a requirement of life-sustaining interventions or that contributed to death” (Card, 2014, p. 7). Four to eight million people are affected by preventable adverse effects in the hospital. The study found that patient harm in a hospital setting is between 25% to 33%. When observing the data from outpatient facilities such as long-term care facilities and pharmacies, combined with

malpractice suits, Card (2014) believes that health-associated harm exceeds heart disease; thus clearly making this a public health issue.

Patient safety significance to healthcare providers and their attitudes

The public health significance of bedside shift report affects many aspects of healthcare. However, the consensus is that patient safety is a top priority. Upon graduating from their respective schools, the majority of licensed healthcare professionals are required to recite a pledge or oath never to cause harm. For example in the Code of Ethics for Nurses, provision three states that: The nurse promotes, advocates for and strives to protect the health, safety and rights of the Patient (American Nurses Association). Nurses stand as the largest group of providers in healthcare. The American Nurses Association reports that there are approximately 3.1 million nurses, and 2.6 million are actively employed (American Nurses Association). The American Nurses Association also suggests that “The public’s high regard for the [nursing] profession, coupled with nurses’ education and skills, makes them well positioned to help transform the healthcare system into one that places more emphasis on prevention, wellness, and coordination of care” (American Nursing Association). One method in which nurses can impact patient safety is through bedside shift report.

The Agency for Healthcare and Research Quality (AHRQ) in their handbook, *Nursing Bedside Shift Report (Implementation Handbook)* state that the goal of bedside shift report “is to help ensure the safe handoff of care between nurses by involving the patient and family” (AHRQ, 2013). Bedside shift report takes place when a nurse going off duty and a nurse coming on duty meet by a patient’s bedside to talk about the patient’s care. The practice gives the patient an opportunity to meet the nurse taking over their care, ask questions, and share important information with the nurses.

Discussing healthcare providers and attitudes is important. Nurses are the frontline staff when it comes to patient care, and they are the healthcare providers who will be performing bedside shift report. Therefore, it is important to determine the overall attitudes of the nurses.

Attitudes are important to healthcare providers because they can affect change. A study performed on physical therapists by Heiwe et al., (2011), found that “Attitudes have been shown to be the individual main determinant factor for evidence-based practice.” Also, their findings highlighted the importance of considering an individual's attitude when working to increase the use of evidence-based practice (Heiwe et al., 2011). Upon determining the nurse's attitudes on BSR, management and administrators can create effective ways to improve the nurses' attitudes and therefore change the practice of nurse to nurse report.

Patient safety significance to medical expenses

Healthcare in the United States is expensive, and as people are getting sicker, healthcare costs are continuing to rise. These increasing costs have led the government and Center for Medicare and Medicaid Services (CMS) to seek ways to reduce excess healthcare expenditures. In the past, hospitals received full reimbursement of the actual amount it cost to provide care to a patient. However, the Prospective Payment System (PPS) was introduced in 1984 to reduce excess expenditures from the reimbursements. With this system, actual expenditures provided to patients did not determine the hospital reimbursement. Rather, hospitals would receive a fixed payment from Medicare that is derived from the admitting diagnosis of the patient (How Hospitals Respond to Changes in Medicare Reimbursements). The Value-Based Purchasing (VBP) program is another strategy Center for Medicare and Medicaid Services (CMS) has recently introduced to decrease excess healthcare costs. CMS defines Value-Based Purchasing as a “program initiative that rewards acute-care hospitals with incentive payments for the quality of

care they provide to Medicare beneficiaries” (Center for Medicare and Medicaid Services, 2015). This method emphasizes the quality of care, rather than quantity of care, which has always been the traditional way. With the VBP program, these four domains are used to evaluate a hospital’s performances, and they affect reimbursement: clinical process of care, patient outcomes, efficiency, and patient experience (Elliot et al., 2016, p. 1675). This current year’s domains and reimbursement percentages are:

1. Patient and Caregiver-Centered Experience of Care/Care Coordination (25%) Safety (20%) Clinical Care (30%)
2. Clinical Care – Outcomes (25%)
3. Clinical Care – Process (5%)
4. Efficiency and Cost Reduction (25%)

Under the patient experience domain, patients are eligible to complete a survey called Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) upon discharge from the hospital.

Patient safety significance to healthcare reimbursement

According to CMS, “The Patient Experience of Care domain score is the sum of a hospital’s HCAHPS base score and that hospital’s HCAHPS Consistency score (Center for Medicare and Medicaid Services, 2015). The HCAHPS is a standardized survey tool that has been used to collect data on patient satisfaction since 2006. The three goals of the HCAHPS tool are:

1. To produce comparable data on patients' perspectives of care that allows objective and meaningful comparisons among hospitals on topics that are important to consumers,
2. To provide public reporting of the survey results which create incentives for hospitals to improve quality of care
3. To enhance public accountability in health care by increasing transparency through public reporting (Center for Medicare and Medicaid Services, 2015).

HCAHPS scores affects the credibility of the hospitals. Hospital's with higher HCAHPS scores have a better reputation among communities and potential future patients. Hospitals are seeking ways to improve their standard of care thus improve ther HCAHPS scores from discharged patients.

Chapter 3: Competencies

For the purpose of the capstone, the following competencies were addressed:

1. Select quantitative and qualitative data collection methods appropriate for a given public health context
2. Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming, and software, as appropriate.
3. Develop logic models to guide evaluation process

Competency 1: Select quantitative and qualitative data collection methods appropriate for a given public health context

The collected data for this study contained quantitative and qualitative data. Qualitative data as stated by Denzin and Lincoln (1994) is a research method in which subjects are studied in their natural settings. The purpose is to attempt to make sense or interpret phenomena regarding the meanings people bring to them (Denzin & Lincoln, 1994). With qualitative data, the goal is to understand the realities of people and communities in the same way that the participant or the community feel it. Denzin and Lincoln (1994) provide examples of a few ways that qualitative data is collected. A few of these examples are direct observations, interviews, and focus groups. For the current study, qualitative data was collected from open-ended questions that were provided at the end of a survey. There are several advantages to using qualitative data. One advantage is that the participants can represent themselves and nothing is predetermined thus making the collected data subjective (McLeod, 2017). Another advantage of qualitative research is that it can suggest possible relationships such as for cause and effect. One disadvantage of qualitative data is that due to the time and cost constraints, it cannot be used for large scaled

samples. Another disadvantage of qualitative research is that because events, conditions, and situations are different, the data cannot be replicated. Finally, analyzing qualitative data sometimes requires experts to interpret the data, for example, data on mental health. The qualitative data from this study were used to develop solutions and recommendations. These recommendations and suggestions can be further analyzed by the administrative members of the hospital to make improvements in educating and rewarding nurses performing bedside shift report, thus impacting patient safety and quality of care.

The quantitative research method collects data in a numerical format to which data can be put into categories, units of measurements, or ranking order (McLeod, 2017). With the data collected from the quantitative method, researchers can display the results in graphs and tables. According to McLeod (2017), the goal of quantitative research is to “establish general laws of behavior and phenomenon across different settings/contexts.” Majority of data collected for quantitative studies is collected via surveys, close-ended questions, or rating scales. Technological software such as Microsoft Excel can be used to interpret collected data. In this project, the survey was used to collect quantitative data. The results of the survey were summarized into *Qualtrics* and projected into *Microsoft Excel* to be displayed in graphs and tables. The Likert-Scale was developed to collect data that was listed into five categories: Strongly Disagree, Disagree, Neutral, Agree, and Strongly Agree. Each of these categories had an associated point attached to it, and this was used to develop an attitude scale. The collected data can also be used by researchers to test a theory to either support or reject it (McLeod, 2017). In this project, the goal was to find out whether a nurse had a positive, negative, or neutral attitude about bedside shift report. The quantitative data that was collected helps researchers and the administrative members of the hospital to see what type of attitudes the nurses had. This

information can be used to develop long-term solutions and methods to improve neutral or negative attitudes.

Competency 2: Analyze quantitative and qualitative data using biostatistics, informatics, computer-based programming, and software, as appropriate.

The second competency that was addressed in this study is the analysis of qualitative and quantitative data by using biostatistics, informatics, and a computer-based programming. The use of programs such as *Qualtrics* and *Microsoft Excel* fulfilled this competency. *Qualtrics* is a simple to use a web-based survey tool to conduct survey research, evaluations, and other data collection activities (Bosch, 2015). *Qualtrics* is a dynamic tool that has over 85 different question types. When developing the project, many survey types were researched, and it was found that the Likert-scale fit best for the project. The program had the same survey setup that was used in the paper survey, the Likert-scale. This project used *Qualtrics* to upload all paper survey which made the collected data easier to decipher. *Qualtrics* was also used to create the graphs and tables that were further analyzed and interpreted in Microsoft Excel. This program is very user-friendly, and there is a live support staff that can assist anyone with the program. Another benefit to using *Qualtrics* is that it is provided by the University of Michigan for free with full access to students, staff, and faculty; and data can be downloaded and exported to other software such as *Microsoft Excel* (Bosch, 2015). Having access to services like *Qualtrics* was beneficial to this project as it was easy to export data from it to *Microsoft Excel*.

Another software that was used to analyze qualitative and quantitative data for this project was *Microsoft Excel*. It is an affordable program that people who have access to *Microsoft Office* can use. *Microsoft Excel* also has “most of the common statistical tests built into it” (Neil, 2001, p 21). In this project, survey data that was uploaded into *Qualtrics* was exported

into *Microsoft Excel*. The raw data was “cleaned up,” and charts, graphs, and tables were created. This program also allows researchers to be able to create and explain graphs and tables. These tables and charts were used to display the responses of the nurses. The graphs were customized to the researcher's preference. A user of *Microsoft Excel* can either enter information manually into the spreadsheet or have the data imported from an online survey tool such as *Qualtrics*. Using these two programs, descriptive statistics were displayed in tables and graphs and easily interpreted for readers to understand.

Competency 3: Develop logic models to guide evaluation process

The next competency that is addressed in this project is the development of a logic model that will be used to guide the evaluation process of the implementation of bedside shift report. According to the Center for Disease Control and Prevention (CDC), the Logic model is a tool that can be used to evaluate a program by providing a visual diagram of how the program is intended to work (CDC). A logic model can be used in all stages of a program. In the case of this project, a logic model was created to evaluate the success of the nursing bedside shift report. To understand the project on educating nurses about bedside shift report, this logic model will be explained in a backward mapping method.

First of all, the defined situation is that nurses are not performing shift report at the bedside. Even though bedside shift report had been implemented by the hospital months before, nurses were not performing report at the bedside. When analyzing the logic model, the question of “what would happen if this problem no longer existed” must be asked. This is the goal of the long-term outcomes and the ultimate impact that the program wants to have. These long-term outcomes are:

1. The Hospital will receive CMS reimbursement because of an increase in patient satisfaction scores
2. Reduction in excess expenditures that are caused by sentinel events such as falls
3. Increased satisfaction of nursing staff due to report given and received promptly
4. Hospital to receive an A grade in the Leap-Frog Group award for patient safety.

The If/Then statement can be used to assess the accuracy of the long-term goals and its relationship to the problem. For example, if nurses performed shift report at the patient's bedside, then the hospital will receive a grade A in the Leap-Frog award for patient safety.

Next is the intermediate outcomes. These are the outcomes that need to take place so that long-term outcomes can occur. An example of this is this statement: a hospital will receive a grade A in the Leap-Frog award for patient safety because sentinel events such as patient falls have reduced throughout the hospital. The intermediate outcome in this example is "there will be a reduction of sentinel events such as patient falls."

The short-term outcomes are the outcomes that need to happen for the intermediate outcome to occur. Short-term outcomes are usually changes in knowledge, attitudes, feelings, perceptions, and understanding. For this logic model, if nurses have a better understanding of how to do bedside shift report, then they would be able to prevent sentinel events such as falls on their units. This will then lead to an overall reduction of falls in the hospital and a grade A from the Leap-Frog Group organization.

The next part of the logic model following the backward mapping method are the outputs. The outputs are the services being delivered and the involvement of the participants. In this logic model, the program will deliver three days of training sessions on bedside shift report, and nurses at this hospital will attend these sessions. So if the hospital is providing these training sessions and the nurses attend, then it is expected that the short-term, intermediate, and long-term

outcomes will occur. Finally, the inputs are the resources that are needed for the program to operate. Examples of inputs in this logic model are funding for food and beverages, staff members and facilitators, a room with media capabilities, and volunteer members of the community.

The logic model works by identifying a programs main components and shows how these components relate to each other. Researchers can use a logic model to evaluate a program and understand the implementation of the program. This logic model was used to evaluate the implementation of Bedside Shift Report re-education for nurses at a local hospital.

See Appendix B.

Chapter 4: Methodology

Purpose of Capstone

Patient safety is one of the top quality improvement priorities for healthcare organizations. Patient safety affects many aspects of health care including patient satisfaction, sentinel events, and medical errors, as well as hospital reimbursements. Communication is one area that hospitals are diligently improving on to prevent medical error sand sentinel events. Every day, thousands of patients are cared for in hospitals and healthcare facilities all over the United States resulting in thousands of opportunity for medical errors. Multiple studies in the past ten years have shown that bedside shift report is an effective way of communicating with nurses. As stated in the report by Street, Eustace, Livingston, Craike, Kent, and Patterson (2011) in their research paper, it is agreed that handover at the patient's bedside not only saves time, but it also allows the nurse to put a face to the name, ensures accurate patient identification, and allows the oncoming nurse to ask questions and begin an assessment (p. 138). Communication in healthcare is vital as displayed by Kohn, Corrigan, Donaldson, and Molla (1999) in their IOM article, *To Err is Human*. In the United States, The Joint Commission is the oldest and largest standards-setting and accrediting body. This organization has set quality improvement goals called the National Patient Safety Goals. Bedside shift report directly impacts two of those patient safety goals:

“*NPSG.01.01.01*: Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

NPSG.03.06.01: Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor” (Joint Commission, 2016).

Bedside shift report has been shown to improve patient safety, patient-centered care, and nurse communication. It also has been shown to reduce medical errors. Gregory et al., (2014) state that “bedside shift reports are viewed as an opportunity to reduce errors and important to ensure communication” (p. 541).

Finally, not only does bedside shift report improve patient safety, but it is also seen to improve patient satisfaction scores, which are crucial to hospital reimbursement. Patients are more involved in their care, there is better communication between providers, and if used properly, BSR decreases nurse to nurse report time (Laws & Amato, 2010).

Although it sounds simple, many nursing staff are resistant to the process of bedside shift report. Upon conducting direct observations on several units at a local hospital, it was discovered that many of the nurses did not participate in bedside shift report even though it was mandated and they had pledged that they would perform it. This set in motion the desire to find out the attitudes that the nurses have about bedside shift report.

This capstone project was an extension of the internship course. The purpose of the capstone project was to evaluate attitudes and beliefs of the nurses on bedside shift report. The idea behind this is that by determining the attitudes of the nurses and developing a force-field analysis (driving forces and restraining forces), the hospital administrators will be able to identify the barriers that need to be addressed for bedside shift report to be successfully practiced throughout the hospital. Also, this project evaluated the hospital’s implementation of bedside shift report by creating a logic model. The study aimed to determine whether the majority of the nurses at this hospital have a positive, neutral or negative attitude about bedside shift report and also to evaluate nurses’ suggestions on the strengths and limitations of the practice.

Capstone development based on Internship experience

The internship experience needs to be briefly explained to understand the study design of the capstone project because it also focused on nursing bedside shift report (BSR), and laid the foundation for the final capstone project. The hospital recently re-introduced the BSR practice to their nursing staff and mandate that every nurse participate in the shift to shift report at the patient's bedside. However, based on managerial observations, many of the nurses at the hospital were not participating with the mandatory method of nurse to nurse report even though this was the second attempt to make BSR the universal practice. Managers and administrative staff had included more education and provided incentives to reinforce the importance of BSR.

Unfortunately, the nurses continued to perform shift report at the nurses' station or hallway, and only performed BSR when a manager or administrative staff was present. The required task of the internship experience was to work on improving nurse's BSR, and the goal was to understand why nurses were not complying with an evidenced-based method that improves patient safety.

The internship project involved direct observations of nurses on two different units. The purpose of the direct observations was to assess the nurses' proficiency in performing BSR after the second go-live. The direct observations of the internship project revealed that there was a lack of competency and enthusiasm to perform BSR. In conclusion to the internship project, the most common barriers that the nursing staff had about BSR were that

1. Report is given and received by too many nurses, and this was time-consuming
2. There are too many interruptions such as patient needs during report time
3. Patient information was not confidential in shared rooms
4. Patients were being woken up and not healing as they should
5. Overall a negative attitude about BSR

These results were brought to the attention of the manager in charge of implementing the BSR project. Please see Appendix A. for an example of the report made to one of the managers.

Attitudes

According to Ostrom (1969) in his study *The Relationship Between Affective, Behavioral, and Cognitive Components of Attitude*, attitudes are described as “a learned predisposition to respond in a consistent evaluative manner towards an object or a class of objects (p. 12). Anvik et al. (2007) believe that a person’s attitude is changed, their behavior can be changed as well. They describe attitude as an evaluation in which good and bad feelings are attached to a topic, an organization, or a person (Anvik et al., 2007). Three main components create an attitude: Affective, Behavioral, and Cognitive. They are nicknamed the ABC’s of attitude. The Affective is the way a person feels, behavioral is the way a person acts, and finally, cognitive is the way a person thinks. (Anvik et al., 2007). The affective component focuses on the emotion that person has about a topic or an object and it reflects emotional reactions. For example, a person may have a fear of spiders, thus leading them to have a negative attitude about spiders. However, after repetitive exposure, the affective component can change. The behavioral component comes as a result of both the affective and cognitive component. A person displays a behavior towards an attitude because of their emotions and thoughts about the attitude. Using the spider example, a person may scream or run away when they see a spider. The cognitive component is the belief and basic value that a person places on the subject matter. With the spider example, a person may believe that spiders are bad. Therefore they would not want to have anything to do with spiders. The interesting thing about the cognitive component is that they are the most difficult component to influence, but when new information is presented, they can be changed (Anvik et al., 2007).

Methods

Human subject protection

The University of Michigan-Flint through the Research Department's Institutional Review Board approved this study. All participants submitted their survey responses anonymously, and the PI obtained and documented the written informed consent when participants received the survey.

Participants

A total of 54 (*n*) nurses completed the survey. Inclusion criteria were that the participant had to be a registered nurse working for this hospital. Participants who were excluded from this study were nurses that did not provide direct patient care or nurses who were in administrative roles, such as a nurse manager or educator. One of the survey responses were not recorded because this participant was a nursing supervisor.

Setting

The capstone project was conducted on all the nursing units at a 158-bed teaching hospital located in the suburbs of Detroit. The various units at this hospital were a medical-telemetry unit, a birthing center and pediatric unit, an orthopedic unit, two intensive care units, and lastly an emergency department.

Hospital requirements

All nurses had previously been required to attend a one-day re-education class, as this was the second time that BSR was rolled out to the nurses. Nurses were required to watch a Powerpoint presentation and were given handouts on BSR and SBAR (Appendix 1). Bedside shift report was originally introduced to this hospital approximately eleven months before the

capstone study initiation, but unfortunately, it had not become “hardwired,” and it was still not part of the culture on some of the units.

Procedures for Implementing

The entire duration for conducting the survey was a total of 3 weeks. The PI initially spent four weeks to develop the survey and gather incentives for participation. The surveys were administered in paper format. One week before handing out the survey, an email was sent out to all bedside nurses informing them about the project and contact information of the PI (Appendix H). Participants were also recruited via face-to-face interactions and flyers displayed around the units. Incentives such as hospital and University of Michigan-Flint branded items were given to each participant that completed the survey. Every participant also had the opportunity to win a grand prize through a raffle ticket. Each survey had an associated double –raffle ticket to go with it. The following are the steps in which the anonymous survey was implemented:

1. There were be two locked boxes available to the nurses: a yellow survey collection box and a green raffle ticket collection box (Appendix C).
2. Blank surveys were handed out to nurses at the nursing station or placed in the nurse’s locker (Appendix E, F, and G).
3. Attached to each blank survey was a set of raffle tickets that had two halves (Appendix D).
4. When the nurse completed the survey, he/she returned the completed survey into the locked yellow survey collection box. (Appendix C)
5. The nurse would hold on to the “Keep this Coupon” half of the raffle ticket and returned the other half to the green raffle ticket collection box (Appendix D).

6. At the end of each week, a raffle ticket was selected from the locked green raffle collection box, and the ticket was given to the unit manager.
7. The winner will need to present their matching raffle ticket to the unit manager for verification. Once verified, the nurse would collect the grand prize, which was a hospital embroidered scrub top.

This two-box method was created to keep the participants confidential. The PI was the only person with access to the boxes, and they were kept in a locked location at all times.

Survey Design

For this study, a survey was distributed to several nursing units at the hospital. This study used a qualitative and quantitative design method. The 5-point Likert Scale was used to gather information about nurses attitude. There was a total of 11 questions in the survey. Eight of the questions were placed on a 5-point Likert Scale. These eight questions were directly related to attitudes (positive, neutral, or negative) nurses had on bedside shift report (Appendix I). The next three questions were related to SBAR (Situation, Background, Assessment, Recommendation), the communication technique that provides a framework for healthcare providers to pass information to each other (Appendix J). The last four questions were open-ended questions, and they were related to what the nurses considered as the strengths and weaknesses of BSR (Appendix 10.). The study's PI created the survey by using items from other tools or instruments.

The Likert scale

The 5-point Likert scale was the tool used because the main topic of this study was to determine attitudes. The purpose of using the Likert scale is that it allows individuals to express how much they agree or disagree with a specific statement. Dr. Rensis Likert was the sociologist from the University of Michigan that developed the Likert Scale technique in 1932 (Bertram

p.1). Dr. Likert wanted to develop a way to measure scientifically psychological attitudes. The goal was to create a method that would “produce attitude measures that could reasonably be interpreted as measurements on a proper metric scale, in the same sense that we consider grams or degrees Celsius true measurement scales” (Bertram p. 1). The benefit of analyzing data from the Likert scale is that specific questions can be studied individually or together with other related questions. When assessing an individual response on a Likert scale, the data collected is ordinal data. This is because the quantifiable differences between the scale, strongly disagree and disagree, for example, are unknown. Descriptive statistics is the method used to present data from the Likert scale. Simple summaries such as bar charts, percentages, and tables will be used to interpret the samples and observations from this study.

Data Analysis

In this study, each of the survey questions was used to determine a nurses attitude on bedside shift report. The open-ended questions allowed the responder to give feedback on how BSR can be improved. The first eight survey questions results were further analyzed, and descriptive statistics were used to organize the results of the surveys. Descriptive statistics are the techniques that enable researchers to summarize a set of number clearly and accurately. The total number of accepted surveys was 53 (*n*). The first eight questions of the survey were directly related to nurses’ attitudes:

1. Bedside shift report is an effective means of communicating
2. Bedside shift report helps identify changes in patient condition
3. Bedside shift report helps assure accountability
4. Bedside shift report promotes patient involvement with their care
5. Bedside shift report improves patient safety and quality of care

6. Bedside shift report is relatively stress-free
7. Bedside shift report is completed in a reasonable time
8. I feel that there are challenges with bedside shift report

Participant demographics included sex, unit, number of years of experience, and shift.

Not all participants completed the demographics section. However, the means and standard deviations are analyzed with the collected data.

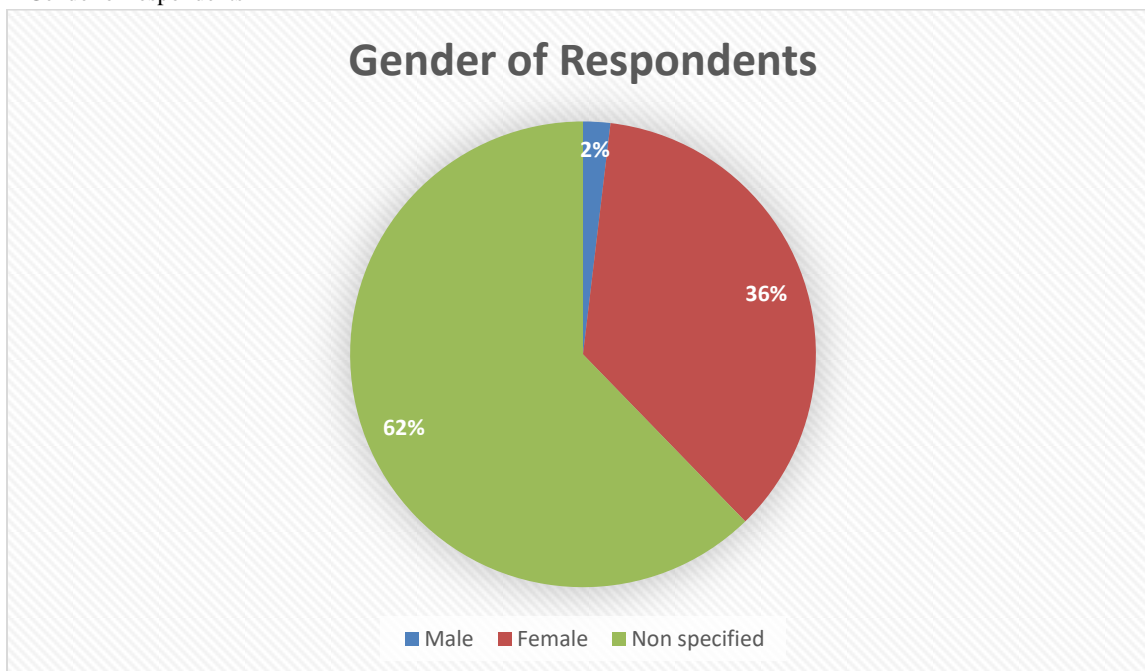
Chapter 4: Results

During the capstone project implementation, 54 nurses returned surveys from the various units at the hospital however only 53 surveys were accepted. Surveys were collected from the medical-telemetry unit, two intensive care units, the joint and hip surgery unit, the maternity and pediatric units, and lastly, the emergency department. All nurses at the hospital were encouraged to complete the survey.

Respondent's Gender

Of the 53 accepted surveys, only one (2%) male nurse and 19 (36%) female nurses disclosed their gender. The following graph shows the breakdown of the respondent's gender and displays the percentage of the responses. Nurses were asked to fill out their gender at the start of the survey, but more than half of the respondents (62%) did not provide this information.

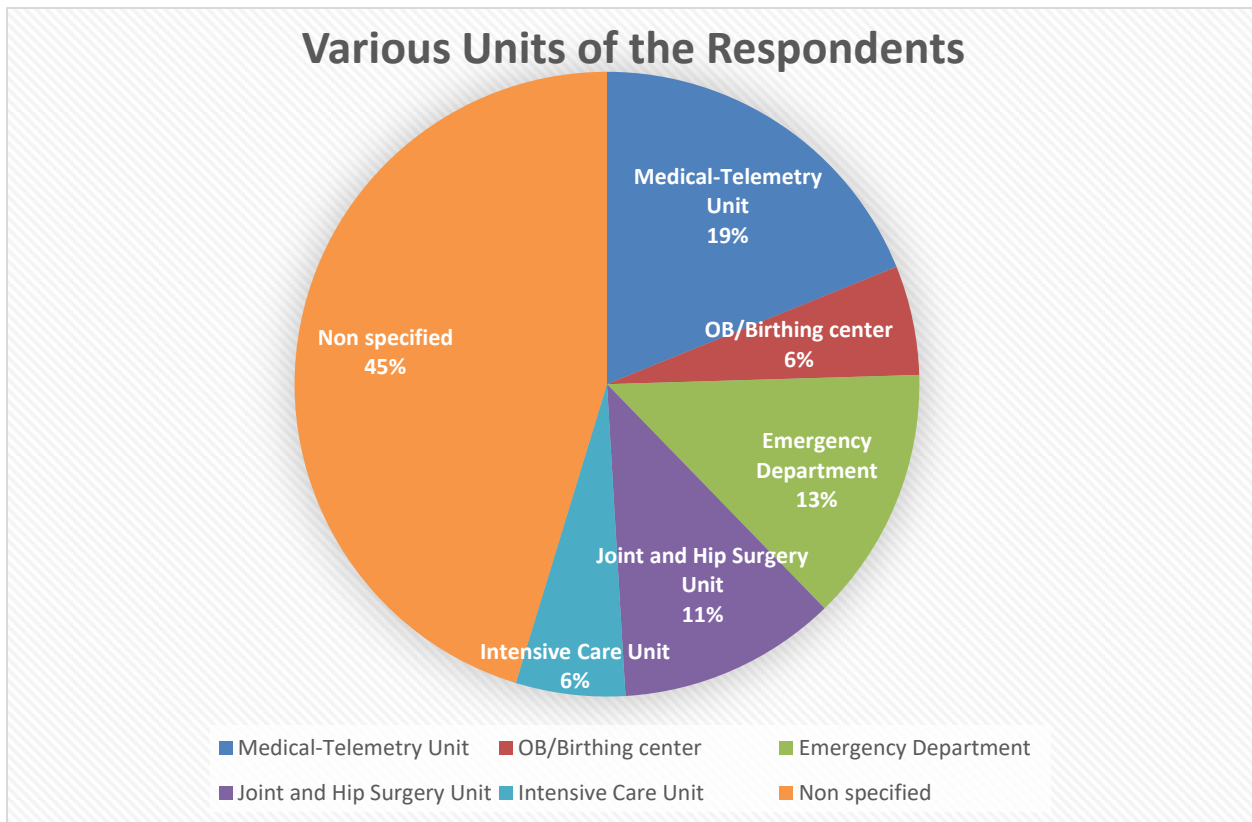
Graph 1.
Gender of respondents



Work location of respondents

Less than half of the participants responded to the question a what unit they worked at. Approximately 30 nurses gave a response to this question with only 24 (n) stating the unit they worked in. Majority of the respondents were from “3 West,” the medical-telemetry unit (19%). This was the first unit to receive the survey. Direct observation also took place in this unit several weeks before the survey was handed out. Surveys were filled out on all the units during the start or end of shift staff huddle, staff break times in the break rooms, and during downtime at the nurse’s station. The following graph shows the different units at this hospital that were surveyed as well as the percentages of the respondents.

Graph 2.
Various Units of Respondents



Responses from questions on Attitudes

The first eight questions of the Likert-scale were directly related to attitudes and how a respondent feels about bedside shift report. This table shows the percentages and number of nurses' responses. A total of 53 responses were reported in this table.

Table 1:
Responses from questions on Attitudes

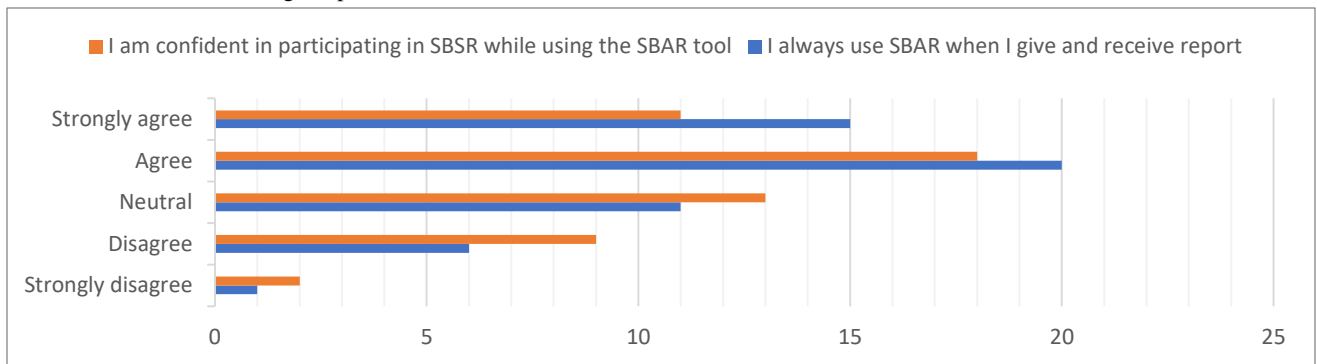
	Strongly disagree % (n)	Disagree % (n)	Neutral % (n)	Agree % (n)	Strongly Agree % (n)
1. Bedside shift report is an effective means of communicating	8% (4)	13% (7)	19% (10)	28% (15)	32% (17)
2. Bedside shift report helps identify changes in patient condition	4% (2)	19% (10)	17% (9)	30% (16)	30% (16)
3. Bedside shift report helps assure accountability	4% (2)	13% (7)	21% (11)	36% (19)	26% (14)
4. Bedside shift report promotes patient involvement with their care	0% (0)	4% (2)	25% (13)	38% (20)	34% (18)
5. Bedside shift report improves patient safety and quality of care	2% (1)	17% (9)	23% (12)	30% (16)	28% (15)
6. Bedside shift report is relatively stress-free	19% (10)	13% (7)	19% (10)	21% (11)	28% (15)
7. Bedside shift report is completed in a reasonable time	19% (10)	21% (11)	23% (12)	25% (13)	13% (7)
8. I feel that there are challenges with bedside shift report	2% (1)	8% (4)	17% (9)	40% (21)	34% (18)

Over half of the respondents agreed or strongly agreed that in regards to communication, Bedside shift report is an effective method to use. More than half of the respondents (60%) agreed and strongly agreed that changes in patient conditions could be identified through bedside shift report. On the subject of accountability, 33 of the nurses (62%) believed that BSR assures accountability. None of the participants strongly disagreed with the statement that "Bedside shift report promotes patient involvement with their care." However, two of the nurses disagreed that BSR promotes patient involvement. Majority of the respondents (49%) "Agreed" and "Strongly Agreed" that BSR is relatively stress free. It should be noted that on this question, as much as 17 nurses (32%) disagreed and strongly disagreed that BSR is stress-free. When discussing the timing and completion of BSR, up to 21 nurses (40% of accepted responses) disagreed and strongly disagreed that BSR is completed in a reasonable time.

Utilization of SBAR among respondents

SBAR is a tool that provides a framework for communication between the nurses. All nurses were required to perform bedside shift report using SBAR as a guideline. From the responses of the survey, 54% (n=29) of the nurses agreed and strongly agreed that they are confident performing bedside shift report while using SBAR. For the question about always giving and receiving patient report with the SBAR tool, only 13% (n=7) strongly disagreed and disagreed with the statement. Meanwhile, 66% (n=35) nurses agreed always to use SBAR when they gave or received report.

Graph 3.
Utilization of SBAR among Respondents



Responses to information received

Nurses were required to answer a question about whether they believed that sufficient information was given during BSR. The responses are tallied in Table 2. While many of the nurses (55%) “Agree” and “Strongly agree” that they receive sufficient information during BSR, approximately 45%, more than a quarter of respondents believe do not agree that sufficient information is given during BSR.

Table 2:
Responses on sufficient information received

	Strongly disagree % (n)	Disagree % (n)	Neutral % (n)	Agree % (n)	Strongly agree % (n)
I am provided with sufficient information about my patient during BSR	13% (7)	13% (7)	19% (10)	42% (22)	13% (7)

Chapter 5: Discussion

The findings from this study suggest that more than half of the nurses who participated in the survey at this local hospital have a positive attitude on bedside shift report. The findings also describe strengths and limitations to the practice of bedside shift report. Many of the survey respondents believed that aspects of bedside shift report are beneficial to patient care and improve patient safety. Nurses also expressed in their survey responses that this method of communicating is effective. The nurses are aware that errors can occur when there is a breakdown in communication, and this can cost a patient their life. However almost half of the nurses that responded to the survey believed that BSR is time-consuming especially for the nurse who has just worked a 12-hour shift. This time-consuming factor is a barrier for why many nurses are not-compliant with the practice. Street, Eustace, Livingston, Craike, Kent, and Patterson (2011) found in their research that 14% of the nurses reported that handover time was too long (p. 136). In their study, they found that the duration of handover ranged from 5-90 minutes, and “handover time was significantly shorter for nurses receiving sole handover compared with those receiving two handovers” (Street, Eustace, Livingston, Craike, Kent, and Patterson, 2011, p. 135). Several nurses who responded to the open-ended questions mentioned that it is time-consuming, with one response stating “getting out of report late” as a barrier to performing BSR.

One aspect of bedside shift report that was not thoroughly investigated in this project was nurses' support and dependence on each other. Communication is a two way street with information being given as well as being received. On the survey question about accountability, the majority of the respondents reported that they BSR ensures accountability between the nurses. This response is similar to the findings of the Street et al., (2011) which reported that

majority of the respondents found verbal and written information an efficient means of handover. Several respondents in the open-ended section reported that receiving patient report from the off-going nurse is a limitation. Some stated challenges are that nurses are unable to give a concise report or that the receiving nurse is unwilling to receive patient report at the bedside, and senior staff do not want to change their habits. However, the responses in the Likert-scale indicate that bedside shift report is not just beneficial for patient safety and quality of care. It also is a way to build “employee teamwork, ownership, and accountability” (Baker, 2010, p. 355). Nurses must depend on each other to get information about the patient and tools like SBAR are simultaneously educated to nurses during the implementation to BSR (Appendix J).

One surprising result that was found from the survey was that a third of the nurse respondents (32%) disagreed or strongly disagreed that BSR is stress-free. Like many other disciplines of healthcare, nursing care is a stressful role. Just as Hamaideh and Ammouri (2011) found in their study *Comparing Jordanian nurses' job stressors in stressful and non-stressful clinical areas*, it is believed that experiencing “job stressors has undesirable effects, both on the health and safety of workers, and on the health and effectiveness of their organizations and clients.” Nurses are particularly impacted by stressors and are found to decrease the quality of the nurses' work, increase some psychiatric morbidity, and may lead to forms of physical illness (Hamaideh and Ammouri, 2011). Some of the open-ended responses stated that bedside shift report adds stress to their job. Another responder said “unnecessary questions that make me uncomfortable” were asked by on-coming nurses that were receiving patient report. Off-going nurses are usually eager to leave after working a 12-hour shift and information can get confusing at that time. In their systematic literature review, Gregory, Tan, Tilrico, Edwardson, and Gamm (2014) found that off-going nurses “reported to frequently ‘apologize for not knowing enough about the patient or not getting everything done’” (p. 544). This can be very stressful for nurses

who have worked their time and are trying to leave. Ortega and Parsh (2013) stated that “When nurses give patient report, their fatigue and stress can lead to information being omitted.” Many distractions and stressors can affect communicating information. There is also the stress of presenting information about a patient in the presence of that patient. Several challenges that were reported by the nurses was that “some reports cannot be discussed in front of the patients,” or “talking about sensitive subject in front of the patient.” These concerns are valid and need to be addressed by the executive members as stress can affect the course of communication and become a barrier.

SBAR (Situation, Background, Assessment, and Recommendation) is the suggested tool that is used to give and receive information. Two of the questions on the Likert-scale were directly related to the use of SBAR. Majority of the nurses who responded to these questions felt confident when using SBAR and also stated that they always use SBAR when they give and receive patient report at the bedside. However, there was a surprising number of nurses who stated that they do not use SBAR to give and receive report. Hospital administrators would like that number to be zero, as SBAR was thoroughly taught to the nurses during the Bedside Shift Report education class. Likewise, Cornell, Gervis, Yates, and Vardaman (2014) concluded in their study *Impact of SBAR on nurse shift reports and staff rounding* that when nurses use SBAR, there is more focus, consistency, and fostering of dialogue in shift report-to-shift report (p. 341).

Limitations

Some limitations were identified and will be addressed in future research. This project was conducted in a small hospital. This limits the number of nurses and thus the number of respondents of the survey. We recommend repeating this study in other facilities with a larger

nursing staff to get a larger sample size. Another limitation of this project was the use of the paper survey. Even though the paper survey was the most effective way to get responses from nurses, using an electronic survey would have been beneficial to reach nurses that were not present on the days that the PI distributed the survey's on the units. In future, the survey should be conducted via an electronic medium. One suggestion on how to get electronic responses is through the hospital open forms. The hospital holds quarterly open forums and those forums would be an appropriate time to target a large number of nurses who attend. The final limitation was that during the time of conducting this project, nursing students from another institution were working on their final project and chose to hand out surveys to the nurses. The content of their survey was similar to the survey that was conducted in this project. The nurses were approached with two similar survey's right after each other, and this may have influenced their responses. In future, groups need to discuss their similar ideas with each other and try to collaborate. If there is no opportunity for collaboration, then there needs to be a discussion of timing between the groups and management to avoid duplication.

Recommendation

The results of this survey are consistent with many of the previously published literature on Bedside Shift Report. A previous study by Jeff et, al.. (2013) found that “nurses viewed the change to bedside shift reporting as improving patient safety and being a more efficient reporting structure” (p. 231). It would be beneficial to the different units to develop a standard report sheet that each nurse can follow. One suggestion is to create a lanyard that nurses could carry on their badges. The SBAR badge lanyard will be a visual reminder to the nurses who may not feel confident when giving patient report, or for nurses who frequently forget to give report using SBAR. There may also be a need for more training for the nurses on SBAR once more. It has

previously been seen that “training in communication had an impact in teamwork that resulted in a significant improvement in patient safety culture” (Stead, Kumar, Schultz as cited by Street et al., 2011, p. 138).

Conclusion

Overall, this study suggests that nurses at this hospital see the importance of effective communication and how it affects quality patient care and safety. In this study, bedside shift report is received as a positive mechanism for reporting information from one nurse to another. Nurses were also educated on SBAR and were required to use this tool during patient report. Nurses also believed that SBAR was a good way to give information to each other. As nurses continue to practice BSR and they become more fluent in it, they improve on reporting to each other within a reasonable time.

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Appendix A

Current findings on BSR:

I began my observations on March 6th. The following information is a summary of my current findings regarding bedside shift report on 3 West:

Total number of observations: 39
 Total number of reports in the hallway: 6
 Total number of reports at the nurse's station: 3
 Time it takes to give report is between 1 minute to 6 minutes
 Patient/family participation: 22 times
 Average number of reports to give per nurse: Not calculated

Findings:

I consider the report as a "COMPLETE" when all components of SBAR is utilized in the appropriate order

In regards to "Total number of reports at the nurse's station" there have been more nurse to nurse reports that have taken place at the nurse's station.

However, I have not directly observed those reports, or I observe them right after observing report from the bedside with another set of nurses.

Updates: I am finding that when a nurse is coming back and receiving updates on a patient he/she had previously taken care of, they are not following the SBAR tool. Most of the time, he/she is given a little update i.e. "They had they ECHO done today, or they have been switched to PO meds."

Patient Participation: Patients are participating in the report. Of course, during the 7p to 7a report, I am finding that more patients are asleep and therefore not "actively" participating. On some occasions, the nurses will give report right outside the door of the patient's room so not to disrupt the patient's sleep

SBAR: I use the attached copy of SBAR to grade the nurses' utilization of the tool. I believe this is the same handout the nurses were given when they attended the Bedside Shift Report class.

- **Situation:** This area is a struggle. I am finding that the oncoming nurse has already looked up the information regarding the patient's name, age, diagnosis, code status, and primary care MD. I believe this information is also provided on the cardex that the nurses handoff to each other. This area is the least addressed area in SBAR. On some occasions, the leaving nurse will say "So this is Jane Doe" and continue his/her report.
- **Background:** Nurses are giving background information on patients. However, a few information such as current therapy, pain, and discharge plans are not frequently addressed.

- **Assessment:** Pertinent information on the patient diagnosis if reviewed. Full system ROS is not frequently included. Nurses do a good job in informing on coming nurse on future needs.
- **Recommendation:** The leaving nurses are doing a good job in informing on coming nurse on patient's future needs (i.e., the patient is going down for a CT scan later, or patient has PT/OT working with them)
- **Thanks:** This area is usually address at the beginning of report or right at the nursing is leaving.

Interruptions: Interruptions are considered to be interruptions that take place during shift report. So far there have been few interruptions that have occurred. 2 times, the interruptions were patients requesting to use the bathroom. On one occasion, the leaving nurse asked the patient if there was anything else he could assist the patient before he left and the patient said he didn't to use the bathroom. At this point, the leaving nurse dismissed the on-coming nurse politely (since the report was just about finished) and he assisted the patient to the bathroom. On another occasion, both nurses were able to get the patient up to the bathroom and continued with report.

Miscellaneous:

On-coming nurses are regularly updating the board as soon as bedside report is starting and they are telling the patient their name and how long they will be here for (i.e., Hi my name is Nurse Huron Valley, and I am going to be your nurse until 3 pm today, or I will be here all night with you).

PCA's are not performing BSR. They are at the nurse's station

Recommendations:

Based on my observations, nurses need more education on SBAR. Many nurses are going to the rooms to give report. However, some nurses, are as one nurse put it, "giving a little blurb" on the patient. Perhaps the nurses can have report sheets that flow in the SBAR style. Also, updates need to be addressed. Should nurses have to give full report if they are updating the oncoming nurse?

Appendix B

Program: Bedside Shift Report Go-live evaluation Logic Model

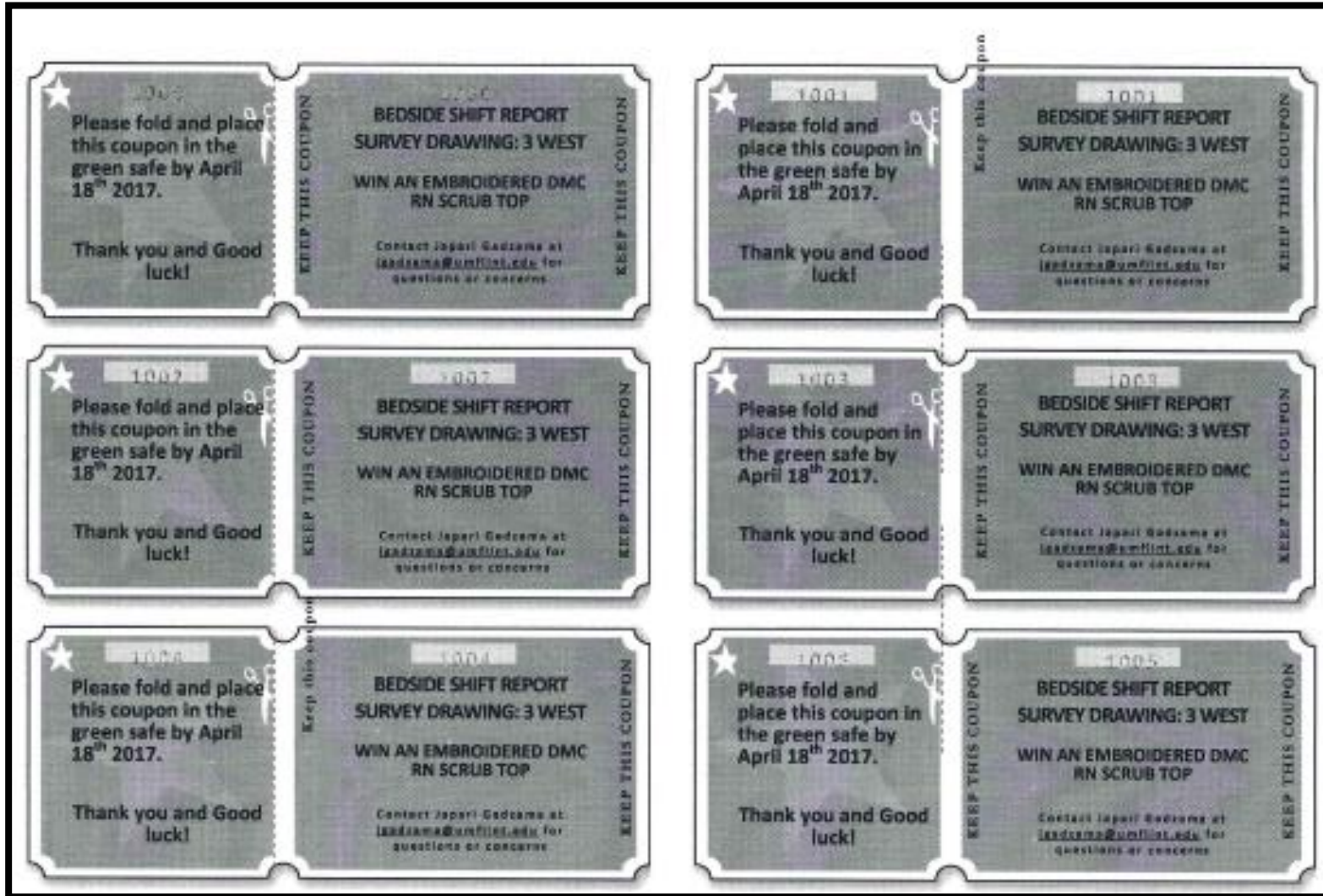
Situation: Nurses are not performing shift report at the bedside

Inputs	Outputs		Outcomes -- Impact		
	Activities	Participation	Short	Intermediate	Long
<p>Budget: snacks and beverages provided to all nursing staff during the 3-day training on Bedside Shift Report; hourly pay for each nurse that attends the training session; coupons for each of the PFACT community members</p> <p>Equipment: Meeting room with media displaying equipment; handouts of Bedside Shift Report and SBAR</p> <p>Community Partners: Members of the community (PFACT) role play as patients during Bedside Shift Report practice</p> <p>Staff: Nurse managers, educators, and members of the Service Excellence office</p> <p>Program evaluator</p> <p>Healthcare providers: All nursing staff at the hospital</p> <p>Prizes/incentives</p>	<p>Provide training sessions to all nurses at the hospital to be trained on performing Bedside Shift Report using SBAR over the course of 3 days</p> <p>Provide presentation of SBAR tool and give scenarios</p> <p>Instruct nurses to demonstrate BSR with PFACT members as their patients</p> <p>Administer prizes to 20 of the nurses who perform BSR using SBAR accurately</p> <p>Conduct a Pre and Post test for Nurses on their knowledge of Bedside Shift Report</p> <p>Nurses who complete the training will sign a pledge stating that they have received training on BSR and will perform it each time they give or receive report</p>	<p>15 PFACT community members</p> <p>Approx. 350 Nurses to be trained</p> <p>10 Trainers/observers who are managers or nurse educators</p> <p>2 facilitators</p> <p>2 Tip sheets: Bedside Shift Report and SBAR for all the nurses</p> <p>3 days of training provided at different times of the day to allow all nurses to participate at their convenience</p> <p>2 hours of training session</p>	<p>Nurses to have a better understanding of bedside shift report and SBAR tool</p> <p>Increase in nurses' confidence in performing bedside shift report</p> <p>Scores to improve from the Pre-test to the Post Test.</p> <p>Nurses to willingly sign a pledge to perform shift report at the bedside with other nurses</p> <p>Nurses who win the incentive for performing BSR using SBAR accurately to be identified as the BSR-unit champions</p> <p>Nurses will have a positive attitude on bedside shift report</p>	<p>Overall reduction of sentinel events such as falls and medication errors that occur in the hospital</p> <p>Nurses to perform bedside shift report during shift change</p> <p>Nurses encouraging each other to perform shift report at the bedside</p> <p>Reduction in communication errors between providers</p> <p>Increased patient knowledge of their care and disease process</p> <p>Reduction of time spent during shift report</p>	<p>Hospital to receive CMS reimbursement due to increase in patient satisfaction scores</p> <p>Reduction in excess expenditure that are related to sentinel events such as falls</p> <p>Increased satisfaction of nursing staff due to report given and received in a timely manner</p> <p>Hospital to receive a Grade A from the Leap-Frog Group for patient safety</p>

Appendix C



Appendix D



Appendix E

Dear Participant:

My name is Japari Gadzama and I am a graduate student at University of Michigan-Flint. For my final project, I am examining Bedside Shift Report between the nurses. Because you are a Registered Nurse, I am inviting you to participate in this research study by completing the attached survey. The following questionnaire will take approximately 5 minutes to complete. There are no known risk involved by completing this survey. By completing the survey, you will have the opportunity to be enrolled in a drawing for a prize of an embroidered "DMC RN" scrub top. In order to ensure that all information will remain confidential, please *do not* include your name. Copies of the project will be provided to my University of Michigan-Flint instructor. If you choose to participate in this project, please answer all questions as honestly as possible and return the completed questionnaires to the large wooden ballot box. Hold on to your "Keep this coupon" part of the drawing and return the other half to the small pink ballot box. Participation is strictly voluntary and responses are anonymous. The winners will be announced on Tuesday April 18th 2017 and the prize will be available for pick up at your manager's office.

Thank you for taking the time to assist me in my educational endeavors. The data collected will provide useful information regarding nurse's barriers and attitudes of Bedside Shift Report. Completion and return of the questionnaire will indicate your willingness to participate in this study. If you require additional information or have questions, please contact me at the number listed below. If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the University of Michigan-Flint Institutional Review Board at 810-762-3384. The research number is HUM00128452. This survey has been reviewed and approved by Jessica Mathiak, Director of Service Excellence DMC Huron Valley Sinai Hospital. Please contact her for any questions or concerns. Thank you for your time!

Sincerely,

Japari Gadzama, RN
810-814-5808; jgadzama@umflint.edu
Dr. Shan Parker
810-762-3172

Dear Participant:

My name is Japari Gadzama and I am a graduate student at University of Michigan-Flint. For my final project, I am examining Bedside Shift Report between the nurses. Because you are a Registered Nurse, I am inviting you to participate in this research study by completing the attached survey. The following questionnaire will take approximately 5 minutes to complete. There are no known risk involved by completing this survey. By completing the survey, you will have the opportunity to be enrolled in a drawing for a prize of an embroidered "DMC RN" scrub top. In order to ensure that all information will remain confidential, please *do not* include your name. Copies of the project will be provided to my University of Michigan-Flint instructor. If you choose to participate in this project, please answer all questions as honestly as possible and return the completed questionnaires to the large wooden ballot box. Hold on to your "Keep this coupon" part of the drawing and return the other half to the small pink ballot box. Participation is strictly voluntary and responses are anonymous. The winners will be announced on Tuesday April 18th 2017 and the prize will be available for pick up at your manager's office.

Thank you for taking the time to assist me in my educational endeavors. The data collected will provide useful information regarding nurse's barriers and attitudes of Bedside Shift Report. Completion and return of the questionnaire will indicate your willingness to participate in this study. If you require additional information or have questions, please contact me at the number listed below. If you are not satisfied with the manner in which this study is being conducted, you may report (anonymously if you so choose) any complaints to the University of Michigan-Flint Institutional Review Board at 810-762-3384. The research number is HUM00128452. This survey has been reviewed and approved by Jessica Mathiak, Director of Service Excellence DMC Huron Valley Sinai Hospital. Please contact her for any questions or concerns. Thank you for your time!

Sincerely,

Japari Gadzama, RN
810-814-5808; jgadzama@umflint.edu
Dr. Shan Parker
810-762-3172

Appendix F

Gender: Unit: Number of years of experience: Work Shift:	Strongly disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
Bedside shift report is an effective means of communicating					
Bedside shift report helps identify changes in patient condition					
Bedside shift report helps assure accountability					
Bedside shift report promotes patient involvement with their care					
Bedside shift report improves patient safety and quality of care					
Bedside shift report is relatively stress free					
Bedside shift report is completed in a reasonable time					
I feel that there are challenges with bedside shift report					
I always use SBAR when I give and receive report					
I feel confident in participating in BSR while using the SBAR tool					
I am provided with sufficient information about my patient during BSR					

Talk *with* your patients not about your patients!

Your opinion is highly valued!
Please complete and return to survey drop box by ___/___/2017. By completing this survey, you will receive a _____ prize and also be eligible for a random drawing of _____ grand prize. Thank you!

Gender: Unit: Number of years of experience: Work Shift:	Strongly disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
Bedside shift report is an effective means of communicating					
Bedside shift report helps identify changes in patient condition					
Bedside shift report helps assure accountability					
Bedside shift report promotes patient involvement with their care					
Bedside shift report improves patient safety and quality of care					
Bedside shift report is relatively stress free					
Bedside shift report is completed in a reasonable time					
I feel that there are challenges with bedside shift report					
I always use SBAR when I give and receive report					
I feel confident in participating in BSR while using the SBAR tool					
I am provided with sufficient information about my patient during BSR					

Talk *with* your patients not about your patients!

Your opinion is highly valued!
Please complete and return to survey drop box by ___/___/2017. By completing this survey, you will receive a _____ prize and also be eligible for a random drawing of _____ grand prize. Thank you!

Appendix G

Open ended questions:

What benefits do you see for performing bedside shift report?

What motivates you to perform bedside shift report?

What barriers/challenges do you see while performing bedside shift report?

What do you need from your manager to make bedside shift report a success?

Appendix H

Gadzama, Japari

From: Mathiak, Jessica R
Sent: Tuesday, April 04, 2017 2:07 PM
To: ZZ-HVSH-RN
Cc: Gadzama, Japari; Doss, Darlene; Nicholls, Henry J.; Leahy, Michael J.
Subject: Attention 2P and 3W RN's

Good afternoon everyone,

I would like to share a feedback opportunity for our nurses on 2 Pavilion and 3 West. Japari Gadzama, RN, a MPH student at the University of Michigan, has been conducting research on these two units as it pertains to Bedside Shift Report. She has asked that I share, that in the upcoming weeks, she will have an anonymous survey for RN's to complete to help her with her study. I encourage you to complete her survey and provide honest feedback. These surveys will not individually be shared, but a collective data set will be prepared for her case study.

The surveys are on paper and will be available in your mailboxes. Please only complete one survey per RN.

Japari's email is attached, so please feel free to contact her with any questions.

Thank you for your participation!
Jessica

Jessica R. Mathiak, RN, MSA
Director of Service Excellence
DMC-Huron Valley-Sinai Hospital
(248) 937-3897

Appendix I

Talk with your patients not about your patients!

Purpose of the survey: To determine nurse's attitudes about BSR and to identify strengths and limitations in current practice of shift report by nurses

Description of Survey: The Survey will be delivered to staff nurses on 3W and 2P. This survey consists of 11 questions placed in a 5-point Likert Scale. The first seven questions are directly related to attitude (positive, neutral, negative) on BSR. The last four open-ended and are related to the strengths and limitations of BSR. All participants will remain anonymous and have a chance to win a random drawing.

Gender: Unit: Number of years of experience: Work Shift:	Strongly disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
Bedside shift report is an effective mean of communicating					
Bedside shift report helps identify changes in patient condition					
Bedside shift report helps assure accountability					
Bedside shift report promotes patient involvement with their care					
Bedside shift report improves patient safety and quality of care					
Bedside shift report is relatively stress free					
Bedside shift report is completed in a reasonable time					
I feel that there are challenges with bedside shift report					
I always use SBAR when I give and receive report					
I feel confident in participating in BSR while using the SBAR tool					
I am provided with sufficient information about my patient during BSR					

***Key to gauge nurse's attitudes**

< 21 – Negative attitude	>22 and <42 – Neutral attitude	>43 – Positive attitude
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Appendix J

Using SBAR for Bedside Shift Report

S = Situation	B = Background	A = Assessment	R = Recommendation
S	<p>Outgoing Provider</p> <ul style="list-style-type: none"> Complete shift – "I am leaving now and Jane will be taking care of your next shift. Jane has... so I am leaving you in good hands." <p>Incoming Provider</p> <ul style="list-style-type: none"> Introduce self using PICO (name, occupation and duty). Updates wheelchair if available. Ask patient to state their name and date of birth, while checking the patient's ID tag. 		
B	<p>Outgoing Provider</p> <ul style="list-style-type: none"> Include the patient – "It is time for me to give my report to Jane and we would like to do this at your bedside so that you can be included. This will give you a chance to ask questions and to add information, which will help Jane to take the best possible care of you. Because we need to do this for all of our patients, it is a quick report – it will only take two to three minutes. If you need more time, Jane will come back later." <p>Incoming Provider</p> <ul style="list-style-type: none"> "Do we have your permission?" 		
A	<p>Outgoing Provider</p> <ul style="list-style-type: none"> Provide information – provide a brief history update including the patient's primary complaint and what assessment/observations have occurred to date with a focus on the last shift and any follow-up that needs to occur. <p>Incoming Provider</p> <ul style="list-style-type: none"> Review chart/subject documentation. Conduct a quick physical exam, if necessary and check all IV sites/pumps for accuracy. Assess patient's care using a pain scale. 		
R	<p>Outgoing Provider</p> <ul style="list-style-type: none"> Review all orders and discuss all care with incoming provider (tests, treatments, medication therapy, IV fluids, etc.). Include relevant medications that have been ordered and any ancillary or support services, e.g., physical/therapy referrals. Ask the patient, "Do you have any questions?" Is there anything else Jane needs to know at this time?" <p>Incoming Provider</p> <ul style="list-style-type: none"> Verify treatment orders/plan of care. Ask outgoing provider and patient/family if they have any additional concerns/questions. Thank the patient. Thank or assure the patient understands the plan of care and is comfortable. 		

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