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A Qualitative Study Evaluating Bedside Reporting and the Impact on Nurse Satisfaction and Communication Barriers with Washington Regional Medical Center

Win Szeto

University of Arkansas, Fayetteville

Sarah Wren

University of Arkansas, Fayetteville

Molly Milborn

University of Arkansas, Fayetteville

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A Qualitative Study Evaluating Bedside Reporting and the Impact on Nurse Satisfaction and
Communication Barriers with Washington Regional Medical Center

An honors thesis/project in partial fulfillment
of the requirements for the degree of
Honors Baccalaureate in Nursing

By

Molly Milborn, Win Szeto, & Sarah Wren
Honors Nursing Students

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University of Arkansas

This honors undergraduate thesis/project is approved for recommendation to the College of
Education and Health Professions Honors Council.

Nancy Smith-Blair
Thesis Mentor
Honors Thesis/Project Director

Jacklyn Gentry
Thesis Mentor

Wendy Sisson
Thesis Mentor

Abstract

Nursing care occurs on a continuum that involves transferring the responsibility of a patient's care from one nurse to another during shift change. Hand-off reports are a vital part of the communication cycle to ensure safe and effective care. Studies have shown bedside reporting increases patient and nurse satisfaction as well as the nurse-patient relationship (Agency for Healthcare Research and Quality, 2013b). The aim of this study was to educate nurses on the importance of bedside reporting and to implement a standardized hand-off. This study was evaluated through two measures. The first measure involved a survey/interview on nurses' perception before and after nurse education on bedside reporting. The second measure involved observation of nurses' behavior during hand-off before and after the educational in-service. Data was collected by nursing students from the Eleanor Mann School of Nursing and the student nurse researchers. The student nurse researchers administered and collected nurse surveys on nurse satisfaction with report and barriers to presenting report at the bedside. Both the student nurse researchers and nursing students observed the nurses during report and recorded data utilizing a checklist (Appendix A). After the educational in-service, nurse compliance with the items on the checklist increased in every aspect except for "reason for isolation" which had no differential at 100% compliance. The nurse satisfaction survey identified one significant area, "Do you feel you gather all the necessary information during report?" and the nurse barrier survey identified two obstacles, "patient not included in report" and "time consuming/not efficient."

Keywords: bedside, report, communication, barriers, satisfaction

A Qualitative Study Evaluating Bedside Reporting and the Impact on Nurse Satisfaction and Communication Barriers with Washington Regional Medical Center

According to the Agency of Healthcare Research and Quality (AHRQ) (2013), a hand-off report is “the transfer of essential information and the responsibility of care of the patient” (What is a Handoff section, para. 1) from one nurse to another. Hand-off is further defined as “an integral component of communication” (Background section, para. 1) between team members that creates a “transfer point” for the “continuity of care” (Background section, para. 1). The primary purpose of hand-off report is to ensure patient safety and it can take on many forms: verbal, written, voice recorded, and at the bedside (Agency for Healthcare Research and Quality, 2013a, Shift-to-Shift section, para. 4). Bedside reporting gives patients the ability to be involved in their care and informs them of up-to-date information regarding their health. The benefits of reporting at the bedside reflect not only on the care received by patients, but also on the ratings of satisfaction received by the hospital.

Review of Literature

Pursuant to Rush (2012), bedside reporting allows patients to stay informed and involved with their care, increases patient satisfaction, decreases anxiety related to the illness, and increases team building between staff members. Rush (2012) reports patients noted nurses were not spending adequate time informing them about their conditions and treatments. Additionally, in a study by Jordan in 1991, as cited in Laws and Amato (2010), 12% of shift reports included care planning for the patient and 2% included an evaluation of the nursing care; however, these failed to provide oncoming nurses with adequate information to provide the best care for each patient. Bedside reporting also allows the patient to meet his/her new nurse, provides the nurse an opportunity to establish a baseline assessment on his/her patient, and initiate prioritization of

his/her patient care load (AHRQ, 2013b; Laws & Amato, 2010). Caruso (2007) states that by reporting at the bedside, nurses reported an increase in finding infiltrated IVs, IV infusions low on fluid, and chest tube drainage that needed repositioning.

Bedside report has shown to increase the accountability of the nurses and the relationships they have with their patients between both the oncoming and off-going nurses (Rush, 2012; Laws & Amato, 2010). Nurses reported an increase rapport with their patients upon implementing bedside report (Caruso, 2007). Caruso (2007) also reports that patients gave positive feedback about bedside hand-off stating they appreciated meeting their nurse and discussing their plan of care. Implementing bedside hand-off report allows patients to see staff teamwork; allows patients to witness a safe professional transfer of responsibilities between shifts; increases patient and nurse satisfaction; decreases patient anxiety; and makes the patient more receptive to care and medical advice (Laws & Amato, 2010). A medical-surgical unit within The University of Michigan Hospital and Health Centers decided to implement bedside report. Desired outcomes they reached included: increased nurse satisfaction with regard to leaving the unit at the scheduled time, an auditory report that allowed ample time for questions, increased patient satisfaction with regards to patient centered care, increased patient clarity regarding their care, and decreased use of call lights (Evans, Grunawalt, McClish, Wood, & Friese, 2012).

Research has shown that 43% of incidents are related to break down in communication due to hand-off issues (Friesen, 2008). In 2008, the Joint Commission issued a National Patient Safety goal of implementation of bedside report requiring standardized information surrounding patient care, treatment and services, current patient condition, and any changes in condition (Laws & Amato, 2010). The Joint Commission issued five patient safety goals which

encouraged interactive communication and allowed the opportunity for questions; updating the patient with information relating to their care, treatments, condition, and any recent or anticipated changes; a process for verification of patient teaching such as a repeat-back method; an opportunity for the receiver to review relevant patient data such as past treatments and labs; and the ability to limit interruptions. Strategies to reach these five patient safety goals included standardizing report and using electronic health records.

At Washington Regional Medical Center (WRMC) in Fayetteville, Arkansas, the current shift change communication is a verbal and written report from the off-going shift nurse to the oncoming shift nurse on the patient's condition. According to Washington Regional Medical Center handbook there is a standard report, but it is not used consistently and does not require the nurse to be at the bedside (J.Bass, personal communication, March 12, 2014). During bedside report, some nurses may enter the patient room while others opt to stand outside the room to talk about the patient as they change shift. Several explanations have been identified surrounding the rationale of doing hand-off report without the patient present including the lack of patient confidentiality and an extensive hand-off report due to patient curiosity resulting in a lengthy report process. Other concerns expressed by nurses included reporting in front of family members and visitors or handling an uncooperative patient (Laws & Amato, 2010). These verbal and written reports may or may not include name, diagnosis, condition, previous surgeries, background, recommendations, labs, and medications. The lack of standardization in this institution may produce a gap in effective communication and lead to adverse events, endangering patient safety, medication errors, delays in treatment, and inappropriate treatment (AHRQ, 2013a & The Joint Commission, 2012). Friesen (2008) noted that ineffective hand-off could contribute to gaps in patient care culminating in breaches in patient safety including wrong

surgery site and patient death. According to The Joint Commission (2012) an estimated 80% of medical errors are due to miscommunication of information during hand-off reports.

Establishment of a protocol will assist in standardized transition of care ensuring safe and effective communication with all parties: nurses, patients, and family members.

Seventy-three percent of WRMC patients rated the hospital as a nine out of ten, which is higher than the national average of 69% (Hospital Consumer Assessment of Healthcare Providers and Systems, 2013). However, when the percentage of patient satisfaction ratings is examined related to the nurses “always” communicating well, WRMC rates at 73%, just below the national average of 78% (Hospital Consumer, 2013). This indicates that WRMC has room for improvement with communication ratings between nurses and patients. The standardization of the bedside report could increase this percentage. The aim of this quality improvement project is to provide an educational activity to nurses about the importance of a quality hand-off report at the bedside. The second aim of the study is to determine if there is a difference in nurse’s perception of use of bedside reports before and after the educational intervention. The study will examine nurses’ satisfaction with hand-off, perception of barriers to providing bedside reports, as well as, observing changes in bedside report compliance before and after implementation of education and a standardized report.

Methods

This study was conducted following approval by the University of Arkansas Institutional Review Board and the Washington Regional Medical Center’s Quality Improvement Department. The study was conducted at Washington Regional Medical Center in Fayetteville, Arkansas on the cardiac unit, also known as the dedicated education unit. Prior to implementation of the bedside report protocol and education at WRMC's April staff meeting, a

personal interview was conducted between student nurse researchers and the nurses on the unit to evaluate nurse satisfaction and identify barriers to hand-off report. A convenience sample was utilized to illustrate current nurse practices during hand-off. The University of Arkansas Eleanor Mann School of Nursing (EMSON) students participating in a clinical rotation at WRMC and the student researchers collected the data and observed the nurses during the bedside report. EMSON students and the student nurse researchers signed Health Insurance Portability and Accountability Act (HIPPA) compliance paperwork.

The student observers evaluated assigned nurses on the cardiac unit during hand-off utilizing a checklist (Appendix A). Students were asked to complete the checklist and return it into their clinical instructor. The student nurse researchers collected the checklists from the instructor and entered data into an Excel spreadsheet. The preliminary data was collected for three weeks prior to the educational presentation on bedside report.

A convenience sample was utilized to interview nurses on the cardiac units regarding barriers to bedside reporting, satisfaction with the current hand-off procedure, and how to improve hand-off report. The nurses were asked questions regarding their satisfaction in communication (Appendix B) prior to and after the bedside report protocol teaching intervention. The survey included items to evaluate barriers that may have existed before implementation of the bedside report protocol. Survey answers were solely for the use of the student researchers to help identify current barriers and possible solutions to increase compliance with bedside reporting.

The education intervention was provided during a staff meeting in which student researchers and the cardiac unit manager provided education on the importance of bedside reporting to the nurses on the cardiac unit. The nurses received a handout summarizing the

presentation (Appendix F) and a sample of hand-off report (Table 1 & Appendix F). The presentation included a poster and emphasized the importance of providing an opportunity for the patient to have questions answered related to his/her care. Following the presentation, all bedside reports were expected to include the nurse addressing patient needs, placing the call light within reach, informing the patient of hourly rounds, updating the whiteboard, updating the nurse on the current shift, and initialing in the appropriate hourly rounding box. After the presentation the nurses were given an opportunity to ask questions from the student researchers. Post-intervention data was collected over a three-week period in the same manner as pre-intervention data collection. Collection of post-intervention data began one week after the educational presentation to allow the nurses to become familiar with the bedside hand-off and allow them an opportunity to become comfortable involving patients in their plan of care.

Results

Data collection took place three weeks prior to the educational intervention and three weeks post education equaling 30 days, 15 pre-intervention and 15 post-intervention. One hundred and eighty-two bedside observation reports were collected during the pre-intervention collection period. One hundred and eleven post-intervention bedside reports observations were collected after the in-service education with a difference of 71 bedside report observations between pre-intervention and post-intervention collections. In the first observation, “Did the nurses enter the patient’s room?” 79% of nurses in the pre-intervention entered the patient’s room. In the post-intervention observations, 95% of nurses were observed entered the patient’s room demonstrating a 16% increase in meeting this criteria (Figure 1).

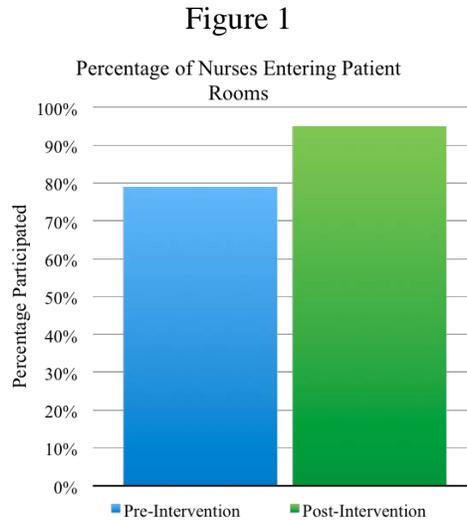


Figure 1. Percentage of nurses entering the patient’s room. This figures illustrates the percentage of nurses that entered the patient’s room pre-educational and post-educational intervention.

The observation regarding the statement of “Diagnosis? Pertinent medical/social history”, the pre-intervention 84% of nurses reviewed this during report, while post-intervention 91% of nurses reviewed pertinent medical/social history following the education intervention for an increase of 7% (Figure 2).

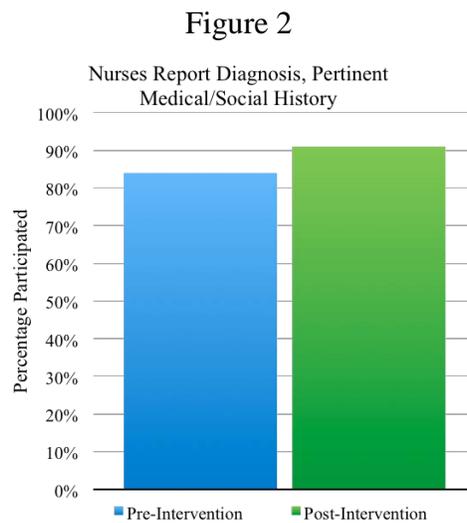


Figure 2. Nurses report diagnosis, pertinent medical/social history. This figure illustrates the percentages of nurses that reported the patient diagnosis, pertinent medical and social history pre-educational and post-educational intervention.

The observation of “General Patient Condition (including topics such as wounds, surgical incisions, dressings, accessory devices, SCDs, PCAs, or dentures)”, the pre-intervention percentage of a nurse stating the general patient condition was 87% and post-intervention percentage was 100% for a total increase of 13% (Figure 3).

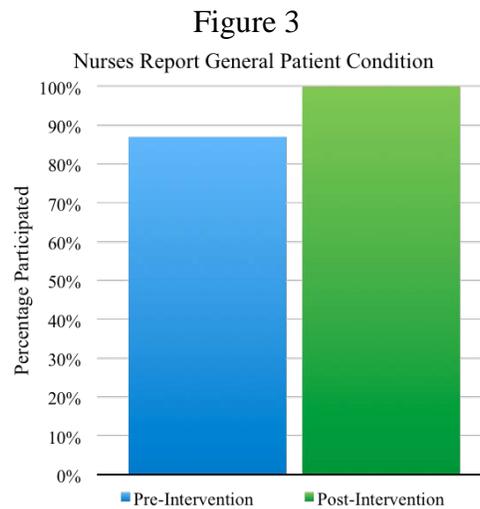


Figure 3. Nurses report general patient condition. This figure illustrates the percentage of nurses that reported the general patient condition pre-educational and post-educational intervention.

For the observation “Plan for the day (stating upcoming procedures, monitoring, upcoming tasks, possible d/c, consults, etc.)”, the pre-intervention percentage was 64% and post-intervention percentage was 94% for a total increase of 30% (Figure 4).

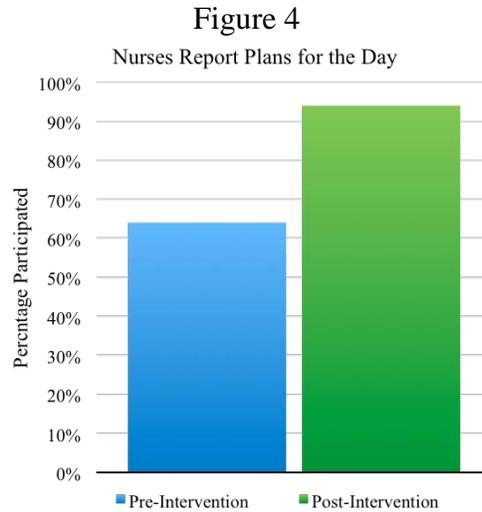


Figure 4. Nurse report plans for the day. This figure illustrates the percentage of nurses that reported the patient’s plan for the day pre-educational and post-educational intervention.

For observation “IV catheter location?” the pre-intervention percentage was 57% and the post-intervention percentage was 64% for a total increase of 7% (Figure 5).

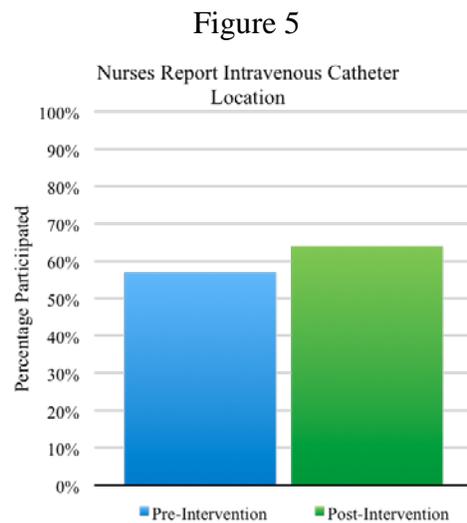


Figure 5. Nurses report intravenous catheter location. This figure illustrates the percentage of nurses who reported intravenous catheter location pre-educational and post-educational intervention.

For observation of the statement “Saline lock or medication infusing”, the pre-intervention percentage was 47% and the post-intervention percentage was 56%, for a total increase of 9% (Figure 6).

Figure 6

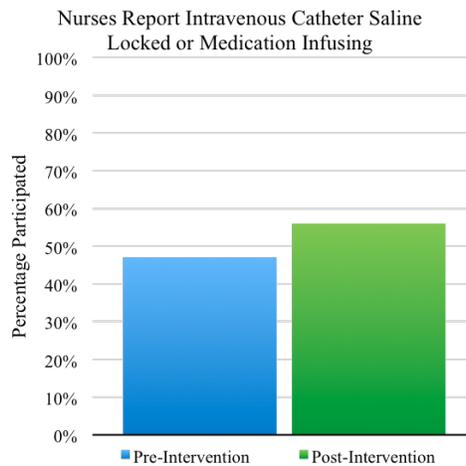


Figure 6. Nurses report intravenous catheter saline locked or medication infusing. This figure illustrates the percentage of nurses who reported what type of medication or fluid was infusing in each intravenous catheter or if it was saline locked pre-educational and post-educational intervention. The observation of “Describes all applicable lines (describe Foley catheter, chest tube, feeding tube, oxygen)”, the pre-intervention percentage was 46% and the post-percentage was 79% for a total increase of 33% (Figure 7).

Figure 7

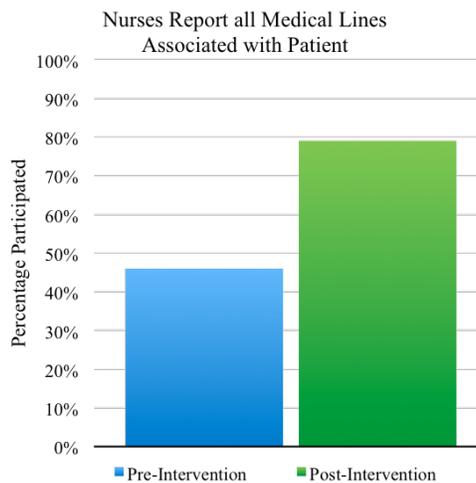


Figure 7. Nurses report all medical lines associated with patient. This figure illustrates the percentage of nurses that reported all important lines such as Foley catheters and chest tubes in a patient during report pre-educational and post-educational intervention.

For the observation of statement “Reason for isolation, if applicable”, the pre-intervention percentage and post-intervention percentage was 100% for no differential (Figure 8).

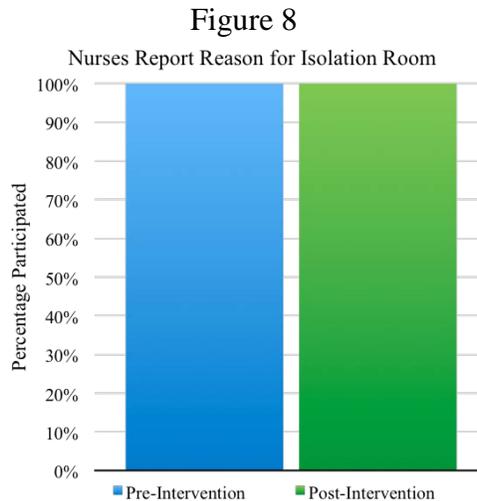


Figure 8. Nurses report reason for isolation room. This figure illustrates the percentage of nurses that reported the reason for patient isolation pre-educational and post-educational intervention.

With the observation of “If the oncoming nurse had to ask questions, indicate if the reporting nurse could answer the questions (Yes/No)”, the pre-intervention percentage showed 58% and the post-intervention percentage showed 67% for a total increase of 9% (Figure 9).

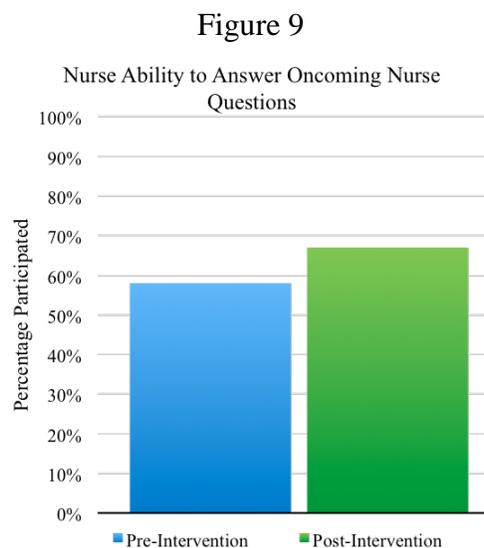


Figure 9. Nurse ability to answer oncoming nurse questions. This figure illustrates the previous shift’s nurse’s ability to answer the oncoming nurse’s questions about the patient and their care pre-educational and post-educational intervention.

For observation of the statement of “Any pertinent information for 1st shift (new meds, last pain med given, etc.),” the pre-intervention percentage was 74% and the post- intervention percentage was 97% for a total increase of 23% (Figure 10).

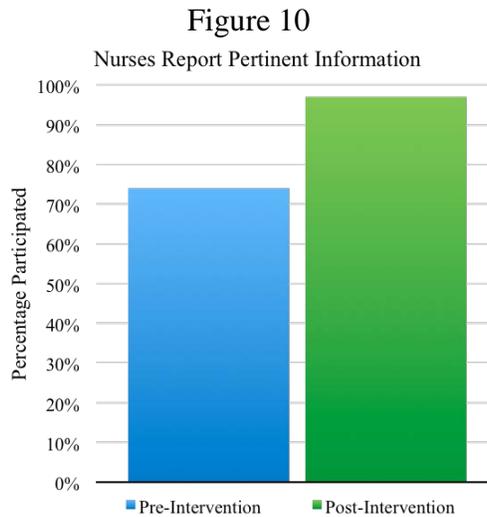


Figure 10. Nurses report pertinent information. This figure illustrates the percentage of nurses that reported pertinent patient information to the oncoming nurse pre-educational intervention and post-educational intervention.

For the observation of nurses who “Presented the report at the bedside?” the pre-intervention percentage was 48% and the post-intervention percentage was 91% for a total increase of 43% (Figure 11).

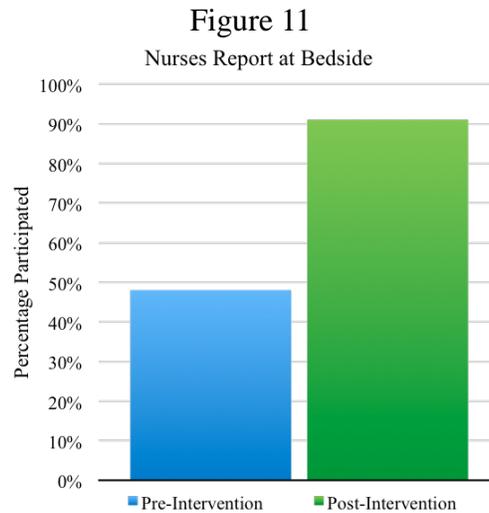


Figure 11. Nurses report at bedside. This figure illustrates the percentage of nurses who performed report at the bedside pre-educational and post-educational intervention.

For the observation of nurses who “Include the patient? (Talking with the patient not just the nurses communicating between each other)”, the pre-intervention percentage was 40% and the post-intervention percentage was 76% for a total increase of 36% (Figure 12).

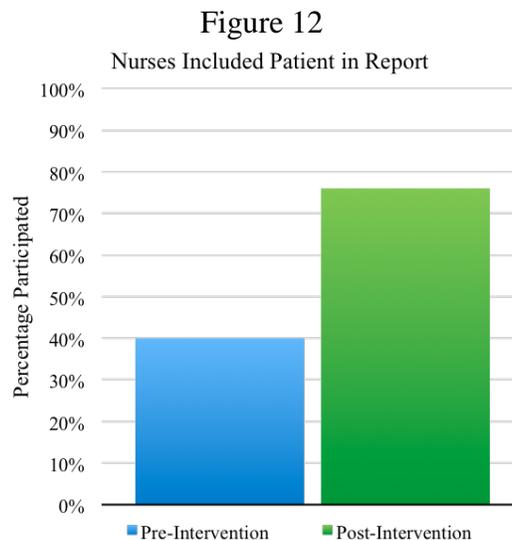


Figure 12. Nurses included patient in report. This figure illustrates the percentage of nurses that included their patient in bedside report pre-educational and post-educational intervention.

For the observation of the nurse to “Ask the patient about his plan of care/goals?” the pre-intervention percentage was 21% and the post-intervention percentage was 8% for a total decrease of 13% (Figure 13).

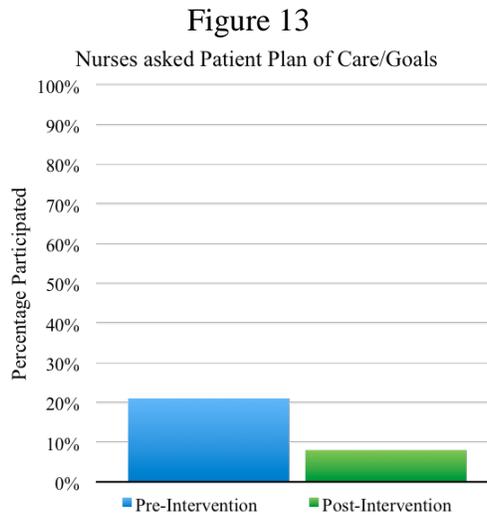


Figure 13. Nurse asked patient plan of care/goals. This figure illustrates the percentage of nurses who asked patients during report what their goals and plan for the day was pre-educational and post-educational intervention.

For the observation, “Ask if he/she can do or get anything for the patient? Ask if the patient had questions?” the pre-intervention percentage was 53% and the post-intervention percentage was 63% for a total increase of 10% (Figure 14).

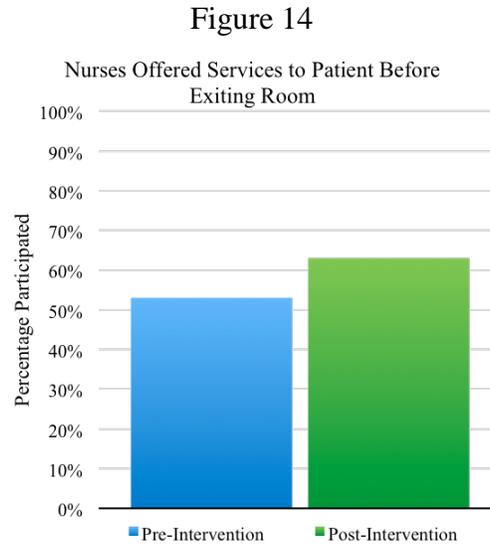


Figure 14. Nurses offered services to patient before exiting room. This figure illustrates the percentage of nurses who offered help or services to the patient before leaving the room during report pre-educational and post-educational intervention.

Other pertinent information that was not recorded in the percentages included reasons for not participating in bedside report. During pre-intervention observations: eight nurses did not enter the patient's room as the oncoming nurses had the same patients on their previous shift. Four nurses did not feel well during time of report and did not want to present at the bedside. Six nurses reported in the hallway, and one nurse did not enter patient's room because they did not want to disturb the sleeping patient. During post-intervention observation five nurses did not enter the patient's room because the nurses had the same patients on their previous shift, one nurse gave patient sensitive information outside the room to oncoming nurse, four nurses did not enter patients' rooms because patients were sleeping, one patient had a language barrier, two nurses were orienting, and one patient had been in the hospital for over two weeks. Fourteen nurses stated they entered the patient's room because of student observation. Tables of the information collected for pre-intervention, post-intervention, and bedside observation results can be seen in Appendices C-E.

Nurse Satisfaction. Twenty-five surveys were recorded for pre-intervention collection and 19 surveys were collected for post-intervention. The Mann-Whitney U-test was used to determine difference between pre and post observations (Table 1). The level of significance was established at $p < 0.05$. The results for the nurse satisfaction survey only revealed a statistical significance for question two, “Do you feel you gather all the necessary information during your hand-off report?” Figure 15 shows the distribution of frequencies of scores.

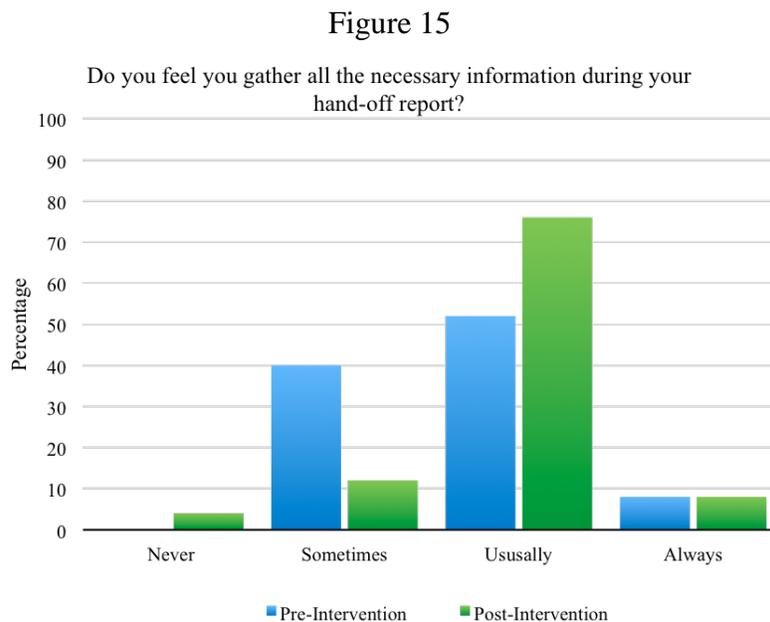


Figure 15. Do you feel you gather all the necessary information during your hand-off report. This figure illustrates the percentage of nurses who felt that they were able to gather all information necessary to provide excellent patient care during each hand-off report pre-educational and post-educational intervention.

Table 1		
<u>Nurse Question Survey P-Values and their significance</u>		
Nurse Question Survey	P-Values	Significance
Question #1: Are you satisfied with hand-off reports during shift change?	0.959	Non-significant
Question #2: Do you feel you gather all the necessary information during your hand-off report?	0.024	Significant
Question #3: Do you go into patient's room for bedside reports?	0.959	Non-significant
Question #4: Do you involve your patient in your bedside report?	0.105	Non-significant
Question #5: Do you feel there is a lack in standardization bedside reporting, which affects your patient's care?	0.781	Non-significant
Question #6: Do you feel like your patient should be included in your hand-offs?	0.828	Non-significant
Question #7: How satisfied are you with the hand-off reports currently?	0.366	Non-significant

Table 1. Nurse question survey p-values and their significance. This table illustrates the satisfaction survey given to nurses to determine their satisfaction with bedside hand-off report and the information they receive during report pre-educational and post-educational intervention. It provides the p-value with whether or not it was significant between pre-educational and post-educational intervention data collection.

Question 8, “What do you think the benefit is to bedside reporting versus report outside the room?” was an open-ended question. In the pre-intervention surveys nurses reported a variety of responses. Three nurses stated the patient is more involved in his or her care and better able to understand. Two nurses responded that clarification of certain assessments such as

wounds helped ensure continuity of care. Three nurses stated seeing the patient helped him or her to remember the pertinent information about the patient. Six nurses responded that verifying wound conditions and IV infusions/sites was important to report. Three nurses stated that patients often contain more information than their charts. Other responses include: assessing the patient's status before assuming care, patients have helpful input, patients are happier when they are informed of their care, involving the patient keeps report professional and concise, and the patient can add any information forgotten during report. Only one nurse remarked that bedside report takes longer because the patient may have something to add and another nurse remarked that nurses want to complete report as quickly as possible so they can go home.

In the post-intervention surveys nurses reported similar answers. Seven nurses stated that the patient is involved in his or her own care. Two nurses reported that the patient better understands his or her plan of care and has up-to-date information. Two nurses commented that visualization is beneficial and alerts the nurse to things that need attention. Visualizing the patient can trigger forgotten information and allows for an initial assessment including wounds, any lines or drains, and mental status to verify the oncoming nurse's findings are consistent with the previous nurse's findings. Including the patient allows for the patient to contribute to his or her care, bring up concerns, correct any misinformation or add any information that is not transferred between the nurses, and address issues immediately. There were comments from some nurses who did not support bedside reporting with reasons including reporting outside of the room is not disruptive to sleeping patients, gives the patients privacy when visitors are present, and allows sensitive material to be discussed.

A Mann-Whitney U-test was used to determine if there was a significant difference between the pre and post Nurse Barrier Survey items. Only the items "Patient not included in

report” and “time consuming/not efficient” were significant with P-values of 0.1 and 0.005, respectively (Table 2).

Table 2		
<u>Nurse Barrier Survey P-Values and their Significance</u>		
Nurse Barriers Survey	P-value	Significance
Culture does not promote successful hand-off e.g lack of teamwork and respect	0.346	Non-significant
Expectations between sender and receiver differ	0.61	Non-significant
Ineffective communication method (verbal, written, bedside, recorded)	0.445	Non-significant
Interruptions during hand-off	0.061	Non-significant
Lack of standardized procedure in hand-off	0.095	Non-significant
Patient not included in report	0.010	Significant
Sender provides inadequate or incomplete information	0.479	Non-significant
Sender has little knowledge of patient at hand-off	0.667	Non-significant
Sender unable to provide up-to-date information e.g. lab results, radiology reports, last medication given, vitals, or not utilizing the COWS or COWs unavailable	0.061	Non-significant
Sender unable to contact receiver in timely manner	0.100	Non-significant
Isolation	0.683	Non-significant
Strains ability to debrief about patient or patient’s situation	0.680	Non-significant
Patient attitude “Difficult patient”	0.313	Non-significant

Table 2		
Nurse Barrier Survey P-Values and their Significance		
Nurse Barriers Survey	P-value	Significance
Time consuming/not efficient	0.005	Significant

Table 2. Nurse barrier survey P-values and their significance. This table illustrates the barriers identified by nurses during shift report as to why nurses do not perform report at the bedside pre-educational and post-educational intervention. The table also includes the P-value for data collected pre-educational and post-educational intervention and whether or not it was significant.

The sixth barrier, “Patient not included in report”, has a significant P-value of 0.010 (Figure 18).

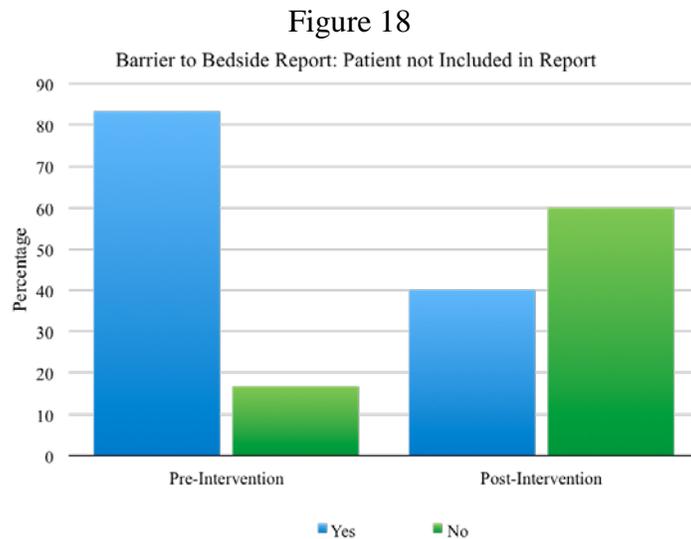


Figure 18. Barrier to bedside report: patient not included in report. This figure illustrates the barrier, “patient not included in report,” demonstrating the percentage of nurses who believe that not including patient in report is a barrier.

The 15th barrier, “Time consuming/not efficient”, has a significant P-value of 0.005 (Figure 19).

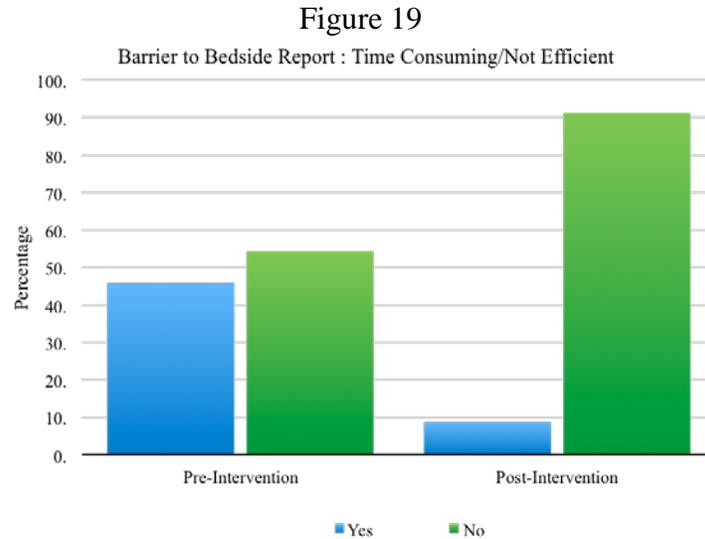


Figure 19. Barrier to bedside report: time consuming/not efficient. This figure illustrates the percentage of nurses who thought that bedside report was time consuming and not efficient, which is why they did not participate in it all the time, creating a barrier. This figure shows the pre-educational and post-educational intervention data.

Discussion

To evaluate the differences of post-interventions for bedside observation, percentages were calculated for each aspect of the observation checklist (Appendices A, C, D, & E). Data for bedside report shows an increase of nurses entering the patient's room as well as including the patient during report, which supports the hypothesis that the occurrence of bedside report including the patient would increase after implementation of education during an in-service on bedside reporting. Overall, there were increases in each observation except for the observation, "Reason for isolation, if applicable." Both pre- and post interventions data revealed 100% compliance for this item. In addition, the observation, "Ask the patient about his plan of care/goals?" showed a decrease of 13% in post-intervention. This could have been from a lack of education during the in-service, ineffective communication, and insufficient amount of time to provide an adequate report.

Overall, the education during the in-service improved standardization of hand-off reports making transfer of care more accurate and safer for the patients. It is hoped that these results will increase WRMC's communication satisfaction rating with patients who received care on the cardiac units, improve team building among staff members, and decrease errors. Although though the plan of care/goals decreased by 13% this area should continue to be addressed in quality improvement efforts. Staff members can be re-educated to include plan of cares/goals during reports, which will allow patients to be more involved and more educated about their care.

A Mann-Whitney U-test was conducted on the nurse/barrier survey to evaluate the hypothesis that nurse satisfaction with bedside report would improve, on average, compared to pre-intervention results. The statistical results showed no significant effect except for question two, "Do you feel you gather all the necessary information during your hand-off report?" In the pre-intervention data, two nurses always felt they had all the information necessary after report, and after post-intervention data, the number of nurses changed to zero. Conversely, 13 nurses stated they usually received the information necessary in the pre-intervention data and 19 stated they usually received it in the post-intervention data. This data is important because it concerns patient safety and whether all pertinent information is passed on in order for the oncoming nurse to provide the best patient care. Although the number of nurses that said "always" changed from two to zero, the amount of nurses that said "usually" increased from 13 to 19, indicating a better general understanding of sharing patient information that is pertinent.

A Mann-Whitney U-test was also conducted to evaluate the hypothesis that barriers to bedside report would be lower, on average, after intervention of an education in-service. The test results did not produce a significant effect except for two barriers, "Patient not included in

report” and “Time consuming/not efficient.” A possible reason for this significant result is that the wording on the survey was misleading. For the barrier “Patient not included in report,” the wording should have read, “Patient included in report,” as the barrier question. The results may have been different if the wording been clearer. During the free response portion of the survey, a few nurses indicated various reasons for reporting outside the room. These included the response of “difficult patients.” This is an issue because the patients and their families need to understand what is occurring with their care. This barrier was addressed in the education provided by the nursing students after pre-intervention data was collected, so emphasis could be given on the importance of bedside report and how it is not time consuming, but actually time efficient. This improvement allows for more informed patients that are able to understand their care and contribute any important information the nursing staff may have overlooked.

As for barrier, “Time consuming/not efficient,” observations showed that the nurses would spend more time interacting with the patients during bedside report instead of performing task oriented interventions and assessments before their morning medication pass. Medication passes are time sensitive and require prioritization with plan of care of patients. This is the main barrier that was found during the surveys creating the resistance against bedside reporting.

Overall, the nurse/barrier survey was not significant. However, this study can be used to further evaluate why nurses do not perform continuous bedside reporting. The results show that additional education may be beneficial as nurses continue to state getting inconsistent reports from nurses giving report when they do not include all the necessary and pertinent information needed to take care of each patient with excellent care. Improvements can always be made in the categories of satisfaction, entering patient rooms, education, and standardization of report.

Limitations

The educational intervention took place during a monthly hospital staff meeting. There was no method of recording nurses who attended the in-services, which limits the ability to accurately track which nurses received the educational intervention that included a poster presentation and an educational handout with Situation, Background, Assessment, Recommendation, Question, (SBARQ) and importance of bedside reporting (Appendix F). In addition to not recording which nurses attended the in-service, there were no nurse identifiers while observing bedside report. Multiple observations may have been performed on the same nurses in both the pre and post-implementation data.

Pre-intervention data collection included observations from nursing students participating in a clinical rotation on the dedicated education unit in addition to the student nurse researchers. The student nurse researchers compiled post-intervention data collection. The inconsistency between data collectors in the pre and post intervention could have created bias in the nurses' behavior related to the quality of their hand-off reports. The nursing students observed report as part of their clinical rotation; therefore, the nurses were less aware of the observation and possibly more likely not to enhance report and skew the results.

Another limitation was the lack of a record of which nurses filled out the nurses/barrier surveys prior to intervention and how many of the same nurses filled out the surveys post-intervention because of the desire to keep the nurses anonymous. Nurse turnover on the dedicated education unit could have also contributed to this discrepancy during data collection, because different nurses were possibly surveyed during pre-intervention and post-intervention. Additionally, new nurses may have filled out the post-intervention survey and not attended the educational intervention. The data notes that two nurses were orienting during post-intervention

data collection confirming this discrepancy. This violates the independence factor in the Mann-Whitney U-test.

A final limitation of this study is the number of nursing surveys filled out prior to intervention and after intervention resulting in different number of surveys due to nurse refusal to complete the surveys. These nurses refused to complete surveys due to time restraints and need to care for patients. Surveys could have been given at a more convenient time for the nurses.

Conclusion

Improvements could have been made in the methods of this research project. Nurse identifiers should have been used during the in-service as well as during observation to avoid duplication of nurse surveys and observations. This would have allowed tracking of which nurses were educated and eliminated the possibility of new nurses on the unit filling out the post-educational intervention surveys as well as being observed for the post-intervention data. These improvements could be implicated in future research. The limited number of statistically significant results in the surveys suggests that the study may not have adequately addressed the aspects of satisfaction or barriers. Further study and evaluation of barrier and nurse satisfaction should be conducted to identify what the most significant barrier is to bedside reporting and how improvements should be made to further improve communication among the healthcare team and with patients.

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Appendix A

Instructions: You will follow your designated nurse during shift report and check the box beside each behavior you observe during rounds. Complete this check list for every patient your designated nurse receives report on. This is to gather data on how reports are done. This survey is completely anonymous for you, the nurse, and the patient. Once the shift report is complete, return them to your clinical instructor. A student nurse researcher will collect them from the instructor.

patients: _____

- Did the nurses enter the patient's room?
- Diagnosis? Pertinent medical/social history?
- General Patient Condition? (wounds, surgical incisions, dressings, accessory devices – SCDs, PCAs, dentures)
- Plan for the day (upcoming procedures, monitoring, upcoming tasks, possible d/c, consults, etc)?
- IV catheter location?
- Saline lock or medication infusing?
- Describes all applicable lines (Foley catheter, chest tube, feeding tube, oxygen)
- Reason for isolation, if applicable.
- If the oncoming nurse had to ask questions indicate if the reporting nurse could answer the questions (Y/N)
- Any pertinent information for 1st shift (new meds, last pain med given, etc)
- Presented the report at the bedside?
- Include the patient? (Talking with the patient not just the nurses communicating between each other)
- Ask the patient about his plan of care/goals?
- Ask if he/she can do or get anything for the patient? Ask if the pt had questions?

Additional information/comments:

Appendix B

Nurse Survey
Nurse to Patient Communication

A student nurse researcher will ask each R.N. on the third floor/cardiac unit at Washington Regional Medical Center the following questions to evaluate barriers and satisfaction with bedside reporting. The nurse will be provided the following information: This interview contains questions regarding your satisfaction with hand-off report and barriers to report especially at the bedside. Your participation is completely voluntary and anonymous.

1. Are you satisfied with hand-off reports during shift change?
a) never b) sometimes
c) usually d) always

2. Do you feel like you gather all the necessary information during your hand-off report?
a) never b) sometimes
c) usually d) always

3. Do you go into the patient's room?
a) never b) sometimes
c) usually d) always

4. Do you involve your patient in your bedside report?
a) never b) sometimes
c) usually d) always

5. Do you feel like there is a lack in standardized bedside reporting, which affects your patient?
a) never b) sometimes
c) usually d) always

6. Do you feel like your patient should be included during your hand-off?
a) never b) sometimes
c) usually d) always

7. How satisfied are you with the hand-off reports currently?
a) never b) sometimes
c) usually d) always

8. What do you think the benefit is to bedside reporting vs report outside the room?

Please mark any of the following you feel is or experience as a barrier to bedside reporting*
*adapted from the Joint Commission's development of the hand-off communication targeted solutions tool

- Culture does not promote successful hand-off, e.g. lack of teamwork and respect
- Expectations between sender and receiver differ
- Ineffective communication method (verbal, written, bedside, recorded)
- Inadequate amount of time
- Interruptions during hand-off
- Lack of standardized procedure in hand-off
- Patient not included in report
- Sender provides inadequate or incomplete information
- Sender has little knowledge of patient at hand-off
- Sender unable to provide up-to-date information, e.g. lab results, radiology reports, last medication given, vitals OR not utilizing the COWs OR COWs unavailable
- Sender unable to contact receiver in a timely manner

OTHER:

Please mark any of the following you feel is a barrier to completing hand-off at the patient's bedside:

- Confidentiality
- Isolation
- Strains ability to debrief about patient and/or the patient's situation
- Patient attitude/"Difficult" patients
- Time consuming/not efficient

OTHER:

Appendix C

Nurse Observations Pre-Intervention Data

Subject	Done	Not Done	N/A	Percentage
Nurse enter patient's room	144	38		79%
Diagnosis, pertinent medical/ social history	157	25		84%
General patient condition	159	23		87%
Plans for the day	116	66		64%
IV catheter location	103	79		57%
Saline lock or medication infusing	86	96		47%
Describes all applicable lines	84	98		46%
Reason for isolation	26	0	156	100%
Answer oncoming nurse questions	106	76		58%
Pertinent information	134	48		74%
Report at bedside	88	94		48%
Include the patient	73	109		40%
Plan of care/goals	39	143		21%
Offer services to patient	97	85		53%

Appendix D

Nurse Observation Post-Intervention Data

Subject	Done	Not Done	N/A	Percentage
Nurse enter patient's room	105	6		95%
Diagnosis, pertinent medical/social history	101	10		91%
General patient condition	111	0		100%
Plans for the day	104	7		94%
IV catheter location	71	40		64%
Saline lock or medication infusing	62	49		56%
Describes all applicable lines	88	23		79%
Reason for isolation	4	0	107	100%
Answer oncoming nurse questions	74	37		67%
Pertinent information	108	3		97%
Report at bedside	101	10		91%
Include the patient	84	27		76%
Plan of care/goals	9	102		8%
Offer services to patient	70	41		63%

Appendix E

Bedside Report Observation Results

Subject	Pre-data Percentage	Post-data Percentage	Differential
Nurse enter patient's room	79%	95%	increase 16%
Diagnosis, pertinent medical/social history	84%	91%	increase 7%
General patient condition	87%	100%	increase 13%
Plans for the day	64%	94%	increase 30%
IV catheter location	57%	64%	increase 7%
Saline lock or medication infusing	47%	56%	increase 9%
Describes all applicable lines	46%	79%	increase 33%
Reason for isolation	100%	100%	no difference
Answer oncoming nurse questions	58%	67%	increase 9%
Pertinent information	74%	97%	increase 23%
Report at bedside	48%	91%	increase 43%
Include the patient	40%	76%	increase 36%
Plan of care/goals	21%	8%	decrease 13%
Offer services to patient	53%	63%	increase 10%

Appendix F

The Importance of Bedside Report

- **Check-list:** 6 Steps to Bedside Report
 - 1. *Introduce* oncoming nurse to patient
 - 2. State reason for *admission/surgery*
 - 3. Discuss *significant events* from shift
 - 4. Discuss any *pertinent information* for oncoming shift (new meds, scheduled surgery, etc.)
 - 5. Review/*assess all lines*
 - 6. *Involve patient*
 - Assess pain
 - State plan for the day
 - Ask:
 - Anything you would like to add?
 - Do you have any questions?
 - Can I get you anything?
 - Tell patient you will be back to see them
- **Out of the room:**
 - Address any psychosocial issues
 - Identify any care/consults needed for continuum of care


FIVE DESIRED OUTCOMES for the PATIENT:

- Informed pt = ê anxiety & é compliance
- Pt meets new nurse at shift change
- ê deserted halls: pts perceive shift change is a time where no one is around
- Sees & hears from the professionals providing his or her care
- é patient satisfaction: pt knows things are being monitored & done

THREE BENEFITS for the NURSE:

- Visualize the patient: learn hands-on with unfamiliar equipment or procedures & prioritize care
- Limits report to items r/t to pt condition and status
- é accountability because the nurse knows the pt condition at end of shift

80% of medical errors are a result of miscommunication at hand-off (The Joint Commission, 2012)
 Increased timely findings of dry IV bags, infiltrated IVs, devices needing draining (Caruso, 2007)
 Decrease in the use of call lights (Evans, Grunawalkt, McClish, Wood, & Friese, 2012)

Situation, Background, Assessment, Recommendations, and Questions (SBAR) Report

Guidelines adopted from Washington Regional Medical Center's policies and procedures

S	<p>“I’m going home now. _____ Will be your nurse today (tonight). I’ve worked with _____ for a long time and I can tell you I’m leaving you in good hands!”</p> <ul style="list-style-type: none"> · State patient name, age · Diagnosis, code status, admit status · Name of primary care physician
B	<p>“I’m about to give report to _____. Please listen so at the end you can ask any questions or fill in any additional information that _____ will need to know to take care of you today (tonight).”</p> <ul style="list-style-type: none"> · Give a brief & pertinent past medical history: explain any co-morbidities or events that led up to this hospitalization or that are having an effect on the patient at this time · Admitted for: · Pertinent History: · Pertinent labs/tests (completed or planned for that day and results, if applicable) Current therapy (meds, treatments, monitoring, dressings, tubes, oxygen, pulse oximetry, IV sites (PICC, CVC lines, Ports) · Current Vital signs · Pain (rating, drug, last dose, follow-up assessment, include patient in discussion) · Other clinical info (PCA/Epidurals – two nurses must check activity level) · Special needs (precautions, isolations, fall risk, dialysis, fluid restrictions) · Consults (physician, social worker, case manager, wound care, dialysis, etc.) Teaching needs (Diabetic, Wound care, Heart Failure, Stroke, VTE, Pneumonia, MI) Ask the patient · Discharge plan and needs (Ask the patient)
A	<ul style="list-style-type: none"> · Inform the oncoming RN of what you have assessed and/or noted during your shift. · Provide a review of systems including: Neuro, cardio-pulmonary, cardiac rhythm, GI, GU, peripheral, skin, activity order, diet order, etc. · Mention all tubes, lines, & drains that are associated with each body system assessed · Include any information or tasks you have completed in the patient’s care · Mention anything the oncoming RN will need to complete or follow-up · Include upcoming procedures, surgery, lab tests, diagnostic studies, etc. · Be specific about what is going on with the patient now
R	<p>“I suggest that you “ (what needs to be followed up on that shift, patient goals, etc.)</p> <ul style="list-style-type: none"> · Review the ordered nursing and medical plan of care with the oncoming RN (IV therapy, antibiotic therapy, tube feedings, etc.) · Include relevant medications that have been ordered and any ancillary support services that are working with the patient such as RT, PT, OT, Nutrition services, Social Services, Discharge Planning, etc. · Include treatments, consents needing to be signed, pre-op checklists, and any education or psychosocial issues going on with the patient or family unit · Inform the nurse about the current plan of care for the patient. · Update the “Communication Board” with this shifts current information <p>“Do you have any questions? Is there anything else _____ needs to know about caring for you today (tonight)?”</p>

Q	<p>“Thanks” – to the patient</p> <ul style="list-style-type: none">· Prior to leaving the room and in the presence of both nurses, ask the patient the following: “Is your pain being well controlled? Do you have any concerns we need to address? Do you understand your plan of care for this hospitalization and your discharge plan?”· Inform the patient of any diagnostic testing to be completed and what he or she can expect during the upcoming shift.· Close with, “We are here to provide you very good care! You are in great hands. Thank you for allowing me to care for you today.”
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