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Hardwiring Bedside Shift Report

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OBJECTIVE: The purpose of this project was to increase nurse compliance with bedside report and increase patient satisfaction scores.
BACKGROUND: Bedside report is an evidence-based practice used to increase patient involvement in their care and improve patient satisfaction. A change management strategy and standardized approach to bedside report can help increase nurse compliance with the process.
METHODS: This study used a quasi-experimental, between-group, preimplementation and postimplementation comparison of patient satisfaction scores from returned surveys on 2 units in a 149-bed community hospital. We also compared nurse compliance with bedside report preimplementation and postimplementation.
RESULTS: Five months after using a change management strategy to "hardwire" (ingrain systems and tools) bedside report, nurse compliance with bedside report and patient satisfaction scores improved in both intervention units.
CONCLUSIONS: A change management strategy and standardized approach to bedside report helped increase nurse compliance with the process, leading to improved patient satisfaction.

The Joint Commission[1] recommends patients to be actively involved in their care and the use of a stan-

dardized handoff communication process during change of care providers. Bedside report addresses both of these requirements. The primary function of bedside report is communication of patients' clinical information and their plan of care from nurse-to-nurse at the change of shift.[2] Failure to communicate pertinent clinical information adequately and consistently during shift report puts patients at risk of harm.[3,4] Patient involvement at the bedside is crucial. Without their involvement, patients have lack of information about their care. Shift report away from the bedside does not allow patient involvement or active participation.[5] A standardized approach to bedside report and manager support of nurses can enhance shift handoff and improve patient safety, outcomes, patient and nurse satisfaction, time management, and accountability.[6,7]

The facility in this project implemented bedside report in 2009 using video education for the implementation strategy. Subsequently, issues of inconsistency in both frequency and quality of bedside report seemed to be related to a lack of nursing leadership support, not holding staff accountable, and failing to address staff barriers, as well as a less than effective implementation plan. The purpose of this project was to increase nurse compliance with bedside report on inpatient units and patient satisfaction. It was surmised patient satisfaction would improve because nurses consistently performed shift report at the bedside. The objectives were to improve compliance with bedside report (process) and ultimately improve patient experience, resulting in improved patient satisfaction scores (outcome).

Hardwiring Bedside Report

Studer[8(p2)] defines hardwiring as a process to "ingrain systems and tools." Management reinforcement with staff regarding the benefits of bedside report has been reported to help gain nurse buy-in with the process.[7,9-12] Addressing staff perceived barriers such as receiving

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report from too many nurses, interruptions to meet patient needs, confidentiality, and waking patients are issues to address before the implementation of bedside report.[7,10,11,13] Using a standardized tool for bedside report is helpful. Researchers report the use of situation, background, assessment, and recommendation (SBAR) as helpful to guide nurses during bedside report.[10,11,14-17] Monitoring compliance with bedside report and mentoring staff for at least 2 weeks have been reported as effective practices in supporting successful hardwiring of the process of bedside report.[6,9-11,17]

Patient Safety and Satisfaction

Patients who experienced bedside report stated feeling safer.[5] Safety scans are opportunities to review the environment for safety concerns or prevention measures and are performed by the care provider. Safety scans during bedside report in the literature include medication review, call light in reach, and reviewing suction, oxygen, and other equipment regarding proper settings and performance. Researchers have reported incidents such as medication errors, falls, and skin tears, decreased after bedside report implementation.[18,19] Patients report better understanding of their care plans and discharge planning with bedside report, thus improving safety. Wilson[2] found patients who experienced bedside report felt more involved in their care, leading to decreased complaints. Patients reported staff focused on them and their needs, worked as a team, and involved them in decisions. Patients felt viewed as partners and active participants with the healthcare team.[20] Families also report feeling bedside report is an essential aspect of care.[2,12] Patients and families have an opportunity to clarify and correct inaccuracies during bedside report. Bedside report encourages and supports patients and families to participate in their desired level of care decision making.[4,7,20,21] Communication with nurses has been reported to improve with bedside report.[9-11,21,22] Overall, patients felt more informed about their care and who was caring for them.[5,14] After participating in bedside report, patients felt nurses listened, explained things in an understandable way, and treated them with courtesy.[11,14]

Opposition to Bedside Report

Several researchers noted concerns with the implementation of bedside report.[2,7,12,18,20] The main concern identified is a breach of patient privacy and the violation of the Health Insurance Portability and Accountability Act.[7,18] Other concerns include the belief that the process will increase shift report time, medical jargon could confuse patients or increase their anxiety, and the patient or family will monopolize the conversation during report.[18,22] Providing educational materials for patients and using a script to inform patients of the process, what to expect, and how they will be involved, including Health Insurance Portability and Accountability Act issues, have been suggested to address these concerns.[7]

Organizational Assessment

We conducted a strengths, weaknesses, opportunities, and threats analysis to assess the organization's current state with bedside report. Strengths include congruence of the model with the mission of the hospital "to serve persons with the greatest care and love."[23] The facility supports a culture of transparency, a nonpunitive approach to errors, and reporting of all safety concerns to a safety hotline. The hospital promotes teamwork through an interprofessional shared governance structure and works collaboratively to enhance patient satisfaction. One organizational weakness was the failure to use a change management strategy during the initial implementation of bedside report; therefore, using Lewin's change theory[15] was identified as an opportunity to hardwire the bedside report process. Another opportunity with bedside report is the hospital's goals to achieve the upper quartile in patient satisfaction as measured by Press Ganey (PG). A threat to the organization is external pressure from the government and payers. Patient satisfaction, as measured by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), is part of Centers for Medicare and Medicaid Services' reimbursement determination.[24]

Framework

Peplau's theory of interpersonal relations[10] and Lewin's theory of planned change[15] provide the framework to reintroduce bedside shift report for this study. In Peplau's theory, nurses aim to establish a therapeutic and trusting relationship during interactions with patients.[10] During bedside report, nurses introduce the oncoming shift nurse, identify patient needs, review progress, and collaborate on the plan of care with the patient. This collaboration leads to an improved trusting relationship. Lewin's framework has 3 phases: unfreezing, moving, and refreezing.[15] Several researchers found the theory useful in hardwiring the bedside report process.[15,17,25] During the unfreezing phase, the investigators presented the evidence behind bedside report, addressed staff barriers, and educated nurses on the impact of bedside report on patient satisfaction and financial reimbursement to the hospital. We worked with a team to conduct nurse simulations of the process and sought staff feedback in the unfreezing phase. In the moving phase, bedside

report began with assistance from the implementation team. They monitored nurses conducting bedside report and then mentored and supported nurses during implementation. In the final refreezing phase, bedside report is hardwired every shift, although not 100%. Studor reports, "Once systems and processes are in place (hardwired) to sustain service and operational excellence, an organization is no longer dependent on a particular leader to ensure continued success."[8(p18)]

Methods

Design, Sample, and Setting

We conducted a quasi-experimental, between-group, preimplementation and postimplementation comparison of patient satisfaction scores from returned surveys on 2 units in a 149-bed community hospital. The units included a 46-bed medical/surgical (M/S) unit and a 12-bed obstetrics (OB) unit. We chose these units because the M/S unit is representative of the larger population in relation to sex and age. For comparison, we selected the OB unit because it has high patient satisfaction scores and a higher current nurse compliance with the bedside report process. We also compared nurse compliance with bedside report from random observation preimplementation and postimplementation.

Procedure

We trained a team to conduct simulations of bedside report and assigned an electronic learning module on the facility's educational system to nurses on both units. The module included evidence supporting bedside report, addressed staff barriers to bedside report, and described the standardized approach to the process. With permission, we included tools from the Studer Group Toolkit[TM26] in a packet given to each nurse. The toolkit included a detailed process on how to conduct bedside report, the SBAR format for the report, a patient letter describing the process for them, and a bedside handoff competency checklist. Next, the team used simulation of bedside report and a competency tool (see Document, Supplemental Digital Content 1, http://links.lww.com/JONA/A517) to check nurses' adherence to the standardized process. The team monitored bedside report using the competency checklist for 2 weeks and then at 1 and 3 months postimplementation. We will monitor again at 6 months. We obtained patient satisfaction scores and patient demographics from the password-protected PG Web site for patients who returned surveys for the 4 months preimplementation and postimplementation.

Instruments

Press Ganey measures patient satisfaction through a survey integrating HCAHPS statements with satisfaction questions.[27] The tools are used by many organizations (n = 935 PG, n = 1066 HCAHPS) to measure patient satisfaction and are supported as being valid and reliable.[27] To determine bedside report compliance, the denominator was the number of nurses observed, and the numerator was the number of nurses who completed bedside report during random observations. Trained observers on each unit conducted observations during shift change on their scheduled shifts. If a nurse conducted bedside report, the observers documented "yes" on the log, and they documented "no" if the nurse did not conduct bedside report (see Document, Supplemental Digital Content 2, http://links.lww.com/JONA/A518).

Human Subjects' Protection

Before the study, we obtained institutional review board approval through the University of Illinois College of Medicine at Peoria and Illinois State University. We sent a consent cover letter explaining the purpose, procedure, risks, benefits, and alternatives to all nurses on the intervention units. We informed nurses that their participation in the random observations was voluntary and provided them with opt-out instructions. All data from PG were de-identified before obtaining them. For the preintervention and postintervention time frames, we obtained mean scores or percent "always" responses for each survey statement and the number of survey respondents with their sex and age. Data from the random observations included numerator (nurses completing bedside report), denominator (nurses observed), and date. Trained observers conducted all observations for 4 weeks before implementation and at 1 month postimplementation. We secured data on a password-protected program on a password-protected computer in a locked office.

Data Management and Analysis

We compared each intervention unit's preimplementation and postimplementation mean score for the 3 statements "nurses kept you informed," "staff included you in decisions regarding treatment," and "nurses explained in a way you understand." We also compared the preimplementation and postimplementation percentile rank in the "large PG database" (n = 723 hospitals) from facility reports. On the HCAHPS survey, we compared the total percentage of "always" responses and percentile rank in the LPG database (n = 1090 hospitals) before and after bedside report implementation for the "communication with nurses" domain and for the statement "nurses explained in a way you understand" from facility reports. For descriptive data analysis of the sample of patients who returned surveys, we used Statistical

Package for the Social Sciences version 22 (Armonk, New York). Patient demographics included sex and age, including means, standard deviations, and range. We conducted a statistical analysis separately or each unit's (M/S and OB) individual patient satisfaction questions and nurse observations of the bedside report process. Statistical analysis included independent-samples t tests to compare preimplementation and postimplementation samples and mean scores for each unit's patient satisfaction survey questions ($P > .05$). We compared the percent compliance with bedside report for each unit (number of "yes" completed report/number of nurses observed) preimplementation to 1 and 3 months postimplementation.

Results

Participants

For the 4 months before implementation, 197 patients returned surveys for the M/S unit, and 93 were returned for the OB unit. For the 4 months postimplementation, 190 patients returned surveys for M/S, and 99 patients returned surveys for OB. There were no significant differences in the 2 samples for either unit (Table 1). Random observations (Table 2) included 132 nurses preimplementation (n = 73 M/S, n = 59 OB), 202 nurses postimplementation at 1 month (n = 147 M/S, n = 55 OB), and 147 nurses at 3 months (n = 94 M/S, n = 53 OB).

Bedside Report Compliance Results

Comparison of nurse compliance with bedside report, as observed through random observations, improved at 1 month on both units (Table 2). Preimplementation observations indicated the nurses complied with bedside report, 12% (M/S) and 55% (OB). Post-

implementation, nurses complied with the process for 85% (M/S) and 84% (OB) at 1 month and 84% (M/S) and 90.6% (OB). These results confirm our hypothesis: the intervention increases nurse compliance with bedside report.

Patient Satisfaction Survey Results

We used independent-samples t tests to compare the mean scores separately for both units for the statements "nurses kept you informed," "staff included you in decisions regarding treatment," and "nurses explained in a way you understand." From facility PG reports, we compared preimplementation and postimplementation percentile ranks for these statements, for the "communication with nurses" domain, and for the statement "nurses explained in a way you understand." We compared the percentage of "always" responses on PG and HCAHPS survey domain "communication with nurses" and the statement "nurses explained in a way you understand" for both intervention units based on facility reports.

M/S Unit

For the statement "nurses kept you informed," the mean score of the preimplementation respondents was lower (mean [SD], 89.95 [15.99]) than the mean (SD) of the postimplementation (92.74 [12.84]) but was not statistically significant ($t = -1.89$, $P = .059$). The percentile rank greatly improved from 22 to 86. Although the mean (SD) improved from the preimplementation group (89.11 [16.12]) to the postimplementation group (91.16 [12.88]), the 2nd statement, "staff included you in decisions regarding treatment," also had no significant differences between the means ($t = -1.359$, $P = .175$) of the 2 groups. The percentile rank improved significantly from 33 to 96. For the "communication with nurses" domain,

Table 1. *Demographic Characteristics of Patient Satisfaction Survey Respondents to Preimplementation and Postimplementation of Bedside Report*

Survey Respondents	Preimplementation, n (%)	Postimplementation, n (%)
OB sex		
Women	93 (100)	99 (100)
OB age, y		
Range	21-50	20-41
Mean (SD)	30.19 (4.56)	29.56 (3.83)
M/S sex	197	190
Women	100 (51)	94 (49)
Men	97 (49)	96 (51)
M/S age, y		
Range	20-95	24-97
Mean (SD)	68.57 (15.67)	67.61 (16.36)

Preimplementation, 4 months before October 1, 2015 to January 31, 2016; postimplementation, 4 months after March 15 to July 13, 2016.
Abbreviations: OB, 12-bed obstetrics unit; M/S, 46-bed medical/surgical unit.

Table 2. Nurse Compliance With Bedside Report

	Preimplementation		1-mo Postimplementation		3-mo Postimplementation	
	n	%	n	%	n	%
OB	33/59	55.9	46/55	83.6	48/53	90.6
M/S	9/73	12.3	125/147	85.0	79/94	84.0

Preimplementation, January 6 to February 12, 2016; postimplementation, March 15 to April 19, 2016 (1 month), and May 15 to June 11, 2016 (3 months).
Abbreviations: OB, 12-bed obstetrics unit; M/S, 46-bed medical/surgical unit.

the percentage of "always" responses increased from 79.6 to 86.8, and percentile rank increased from 52 to 99. For the statement "nurses explained in a way you understand," the mean (SD) score improved from 92.22 (14.79) to 94.3 (11.54) but was not significant ($t = -1.158$, $P = .248$). The percentage of "always" responses increased from 75.2 to 81.0, and percentile rank increased from 43 to 94 from preimplementation to postimplementation (Table 3).

Obstetrics

For the statement "nurses kept you informed," the mean (SD) score of the preimplementation respondents was slightly higher (96.56 [10.48]) than the mean of the postimplementation respondents (96.36 [10.44]) but was not statistically significant ($t = 0.129$, $P = .897$). Although the mean (SD) improved from the preimplementation group (94.26 [13.95]) to the postimplementation group (95.51 [9.32]), the

Table 3. Patient Satisfaction Survey Responses

Survey Respondents	Preimplementation, Score/Rank/%	Postimplementation, Score/Rank/%	t	P[a]
Patient satisfaction statements				
OB				
"Nurses kept you informed"				
Mean (SD) score	96.56 (10.48)	96.36 (10.44)	0.129	.897
Percentile rank[b]	99	99		
"Staff included you in decisions regarding treatment"				
Mean (SD) score	94.26 (13.95)	95.51 (9.32)	−0.736	.463
Percentile rank[b]	99	99		
"Communication with nurses"				
Percentage of "always" responses[b]	90.60	94.60		
Percentile rank[b]	99	99		
"Nurses explained in a way you understand"				
Mean (SD) score	97.80 (7.12)	97.55 (8.34)	0.216	.829
Percentage of "always" responses[b]	92.10	91.90		
Percentile rank[b]	99	99		
M/S				
"Nurses kept you informed"				
Mean (SD) score	89.95 (15.99)	92.74 (12.84)	−1.89	.059
Percentile rank[b]	22	86		
"Staff included you in decisions regarding treatment"				
Mean (SD) score	89.11 (16.12)	91.16 (12.88)	−1.359	.175
Percentile rank[b]	33	96		
"Communication with nurses"				
Percentage of "always" responses[b]	79.60	86.80		
Percentile rank[b]	52	99		
"Nurses explained in a way you understand"				
Mean (SD) score	92.22 (14.79)	94.30 (11.54)	−1.158	.248
Percentage of "always" responses[b]	75.20	81.80		
Percentile rank[b]	43	94		

Preimplementation, 4 months before October 1, 2015 to January 31, 2016; postimplementation, 4 months after March 2015 to July 13, 2016.
Abbreviations: OB, 12-bed obstetrics unit; M/S, 46-bed medical/surgical unit.
[a]Significance set at .05 level.
[b]Obtained from facility reports.

2nd statement, "staff included you in decisions regarding treatment," also had no significant differences between the means ($t = -0.736$, $P = .463$) of the 2 groups. For the "communication with nurses" domain, the percentage of "always" responses increased from 90.6 to 96. For the statement "nurses explained in a way you understand," the mean (SD) score decreased slightly from 97.8 (7.12) to 97.55 (8.34) but was not significant ($t = 0.216$, $P = .829$). The percentage of "always" responses also decreased from 92.1 to 91.9. The percentile rank remained at the 99th from preimplementation to postimplementation for all statements (Table 3).

Discussion

Nurse compliance with bedside report increased on both units. Patient satisfaction mean scores, percentile rank, and percentage of "always" responses improved on all 4 statements for M/S. For OB, the satisfaction mean score improved on 1 statement and decreased slightly on 2 statements. The percentage of "always" responses improved on the "communication with nurses" domain and decreased slightly on 1 statement. The percentile rank for OB remained high at 99. Whereas M/S demonstrated high improvement, the OB unit saw less improvement. The OB unit had higher percentage compliance (55.9%) with bedside report preimplementation than M/S (12.3%), which may account for the difference in degree of improvement. There are a number of factors affecting the results. First, presenting the evidence supporting bedside report, addressing staff barriers, and educating nurses on the impact of bedside report on patient satisfaction were crucial to gain staff buy-in. Second, the use of a competency tool for the bedside report process helped to ensure standardization. Third, the support of organizational leadership set the expectation and allowed resources to monitor the implementation for the 1st 2 weeks. Unexpected findings included the length of time it took to hardwire nurse compliance. The implementation team monitoring of nurses conducting bedside report and providing immediate feedback to nurses assisted in gaining buy-in, but nurse compliance took longer than we expected. To sustain the change, trained observers conducted random observations of nurse compliance with bedside report at 1 and 3 months after the postimplementation 2-week monitoring ended. The observers will repeat random observations at 6 months postimplementation. We presented the comparison results of the preimplementation and postimplementation bedside report compliance and patient satisfaction to staff, managers, and directors of the units. In charge nurse meetings, we explained expectations to continue monitoring compliance and addressing issues with nurses. Without continued monitoring vigilance, the compliance with the process could decrease. Three months was deemed too brief a time frame to ingrain a new process.

These results are consistent with the following literature. Addressing staff barriers to bedside report, using a standardized approach to the process, and using SBAR help gain nurse buy-in to the process.[7,10,11] Monitoring nurses conducting bedside report for at least 2 weeks is effective in hardwiring compliance.[6,9-11,17] Bedside report is effective in improving patient satisfaction scores for communication with nurses,[9-11,21,22] keeping patients informed,[5,14] and explaining things in a way they understand.[11] The purpose of this project was to increase nurse compliance with bedside report and patient satisfaction scores. A change management strategy and standardized approach to bedside report helped increase nurse compliance with the process on these 2 units.

Limitations

We conducted this project at 1 community hospital on 1 OB unit and 1 MS unit. This limits generalizability to other facilities and patient populations. We recommend repeating the study in other facilities, including other samples. We also only randomly observed nurse compliance with the bedside report process. The actual compliance with the process is difficult to measure due to the inability to monitor every nurse on every shift. Other factors may influence patient satisfaction so we cannot generalize increased compliance with bedside report is solely responsible for the significant improvement. Further research controlling for other patient satisfaction factors may address this limitation.

Conclusions

As organizations continue to implement evidence-based practices in a rapidly changing environment, providing resources and support to manage the change is important. A change management strategy and standardized approach to bedside report helped increase nurse compliance with the process. The use of Lewin's theory of planned change[15] was effective in increasing nurse compliance with bedside report, leading to improvement in patient satisfaction. We achieved improved compliance with bedside report by educating nurses, addressing nurse barriers, standardizing the process, monitoring, and providing leadership support.

Acknowledgments

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