Incorporating Bedside Reporting into Change-of-Shift Report

Dawn Laws, BSN RN CRRN • Shelly Amato, MSN RN CNS CRRN

KEY WORDS

bedside report
change of shift report
hand-off communication

Communication failures during shift reports are a leading cause of sentinel events in the United States. Providing adequate information during change-of-shift reporting is essential to promoting patient safety. In addition, patients want to be more involved in decisions regarding their plan of care. The purpose of the article is to discuss how a stroke rehabilitation unit was able to implement bedside change-of-shift reporting to meet both of these goals.

Implementing a standardized approach to hand-off communication is a key component of one of the 2007 National Patient Safety Goals for Hospitals established by the Joint Commission (2006). This goal was established to improve the effectiveness of communication among caregivers and emphasize the importance of allowing caregivers the opportunity to ask and respond to questions during hand offs, including change-of-shift reports. The Joint Commission (2000) has identified communication failures during shift reports as a leading cause of sentinel events in the United States. Providing adequate information during change-of-shift reporting is essential to promoting patient safety; however, information is often lost during traditional audiotaped reports. Oftentimes, repetitive and irrelevant information is passed on while key information is left out.

Although patient safety is the focus for nursing staff, involvement in the plan of care is fast becoming an expectation of healthcare consumers. With massive amounts of information available on the Internet and provided by television and radio, patients are more knowledgeable about their health and want to be involved in the process of planning their own care. Nursing staff are faced with the challenge of providing an efficient change-of-shift report that records essential information to promote patient safety, while including the patient in the care-planning process. The purpose of this article is to discuss how a stroke rehabilitation unit was able to implement a bedside change-of-shift reporting process to meet both of these goals.

Background

Drawbacks of Traditional Change-of-Shift Report

Traditionally, change-of-shift reporting has been performed away from the bedside either with an audiotaped or verbal report. Shift reports have often been unstructured, repetitive, and lacked consistency in the type of information provided by each individual nurse. Johnson and Web (1995) found that nursing report assessments are frequently subjective in their content and accompanied by value judgments and labeling of patients. In addition, shift reports often lack care planning (Mosher & Bontomasi, 1996), which leaves nurses without a focus for how to best assist in meeting patients' goals during their shift. In a study by Jordan (1991), only 12% of change-of-shift reports included care planning and 2% included evaluation of nursing care. These issues often left nurses with insufficient information to provide patients with the best possible care and limited patients' input into their own plan of care.

Shifting from an audiotaped or verbal report to a nontraditional bedside report can be a difficult transition for nurses. Issues of concern that make the transition difficult include confidentiality; length of report; and discussion of sensitive items such as a new diagnosis, test results, and issues surrounding difficult or noncompliant patients. In a study done by Anderson and Mangino (2006), concerns regarding confidentiality were a major issue when attempting to shift from a change-of-shift report in a private conference room to a report at the bedside. Caruso (2007) also identified confidentiality as an issue in her hospital, where change-of-shift report was conducted in private rooms. Another concern among nurses was that a bedside report could lengthen rather than shorten a report. Anderson and Mangino found that their staff was concerned that patients would ask questions and interact with nurses during the change-of-shift report, resulting in lengthy reports.

Benefits of Bedside Report

Despite the challenges in implementing a bedside change-of-shift report, research has shown benefits of this process. Given the complexity of health care today and changing technology, it is challenging for nurses to communicate with patients to ensure their safety. One of the benefits of bedside report for the staff nurse is the oncoming nurse's ability to immediately confirm the previous shift's report by visualizing the patient and getting a baseline assessment to compare

against changes during the shift (Richard, 1989). This also allows the nurse to plan and prioritize patient care and manage the patient load effectively. Reports of inconsistency between the information provided and the actual status of the patient were found by a number of researchers who study shift-report methodologies. These findings support the understanding that a nurse should not trust that the information given during a report matches the actual status of the patient (Strople & Ottani, 2006). Accountability between shifts is promoted by direct observation of the patient by both oncoming and off-going nurses. Another benefit for nurses includes improved interaction. Staff relationships are enhanced when communication, an important nursing skill, is promoted (Anderson & Mangino, 2006). As a result, staff work together as a team and enhance the professional image of nursing.

The nurse-patient interaction during bedside report provides benefits to both patients and nurses. A bedside report reassures the patient that the nursing staff works as a team and that everyone knows the plan of care. By working together, patients witness a safe, professional transfer of responsibilities. Patients can ask questions or contribute information to the discussion. Allowing the nurse and patient an opportunity to share information promotes involvement and improved satisfaction. Evidence suggests that patients involved in their care are less anxious and more likely to follow medical advice, start treatments earlier, and, therefore, are able to select lower-risk interventions and litigate less (Anderson & Mangino, 2006). Making reports more patient focused encourages individualized care and promotes active participation in the plan of care. In turn, patients are more satisfied and more apt to become loyal customers (Anderson & Mangino).

The Foundation for Change

Several factors contributed to the decision to institute bedside reporting on the stroke rehabilitation unit. Initially, a discussion ensued at the practice council meeting about one of The Joint Commission's 2006 National Patient Safety Goals. The goal requires that hand-off communication be standardized. Specifically, The Joint Commission says "effective hand off" communication should include current information regarding the patient's care, treatment and services, current condition, and any recent or anticipated changes (Schroeder, 2006). However, the rehabilitation unit used an audiotaped report that did not have a standard format; therefore, the content of shift report would sometimes degenerate into irrelevant and outdated statements. The Joint Commission has identified communication breakdown as the main cause of sentinel events in the United States and identifies shift report as a contributing factor (Strople & Ottani, 2006). Inaccurate information, omissions, and communication breakdowns can have serious consequences for both patients and staff.

Key Practice Points

1. The communication process at bedside meets the needs of both patients and nurses by providing an opportunity to improve patient safety and increase patient collaboration in the plan of care.
2. Bedside reporting reassures patients that the nursing staff works as a team, and patients witness a safe, professional transfer of responsibilities.
3. The Joint Commission has identified communication failures during shift reports as a leading cause of sentinel events in the United States.

A second impetus for change was patients' desire to be more involved in the plan of care. An informal survey of patients in our unit indicated that most patients wanted more information about their condition as well as information regarding short- and long-term goals. Today, patients want to be involved or at least informed about healthcare options and alternatives (Anderson & Mangino, 2006). Bedside reporting supports this collaborative model of informed choice and active patient participation.

The final factor that influenced the decision to change to bedside reporting was the philosophy of nursing within our organization. A Nursing Partnership Model of Care guides our nursing practice. Collaborative relationships with other members of the healthcare team and our patients are central to this model. Specifically, the delivery of nursing care integrates principles of research, evidence-based practice, critical thinking, and ongoing education through collaborative relationships with patients and families (MetroHealth Medical Center, 2002). The goal was to build a partnership with the patient and family that promotes interaction through open communication and mutual transactions. Implementing bedside reporting was congruent with our nursing philosophy and supports a collaborative approach to how nursing care is delivered.

The Challenge and the Vision: Implementation of Bedside Report

The decision to implement bedside reporting on the stroke rehabilitation unit was supported and encouraged by the nursing administration. In fact,

Figure 1. True Statements According to Nurses—Preimplementation

1. Bedside report can improve patient safety.
2. Bedside report violates patient confidentiality.
3. Bedside report provides an opportunity for patients to discuss their plan of care.
4. Bedside report takes longer than taped report.
5. Bedside report holds off-going staff more accountable than taped report.
6. Bedside report reassures patients that staff work as a team.

Comments:

the results of a recent satisfaction survey expressing the patient's need to be more actively involved in the plan of care, coupled with the 2006 National Patient Safety Goal, further confirmed that bedside reporting could provide a safe and informative hand-off communication method.

A preimplementation survey was administered to nurses on our unit. They were asked to circle all statements regarding bedside reporting that they believed to be true (**Figure 1**). Results indicated that many nurses were reluctant to change their routine methods of using audiotaped reports. When asked to identify any concerns they had about bedside reporting, many nurses responded with a variety of issues. Concerns regarding patient confidentiality were frequently mentioned throughout many surveys. They also feared situations in which patients would talk or ask questions for extended periods of time, thereby making the report process too long. Many were unsure of how to address other circumstances such as reporting in front of family members or dealing with uncooperative patients.

The ability to rally the nurses behind the idea that bedside reporting could be beneficial to both patients and staff was another challenge. The planning process to implement the proposed change began with a shared vision and a specific focus. To identify rationale for the change, information about bedside reporting was shared with staff through journal articles and staff meetings. The benefits were emphasized, including improved patient safety via direct visualization during rounds and improved patient satisfaction as a result of the partnership between nurse and patient during rounds.

Collaboration of the Team

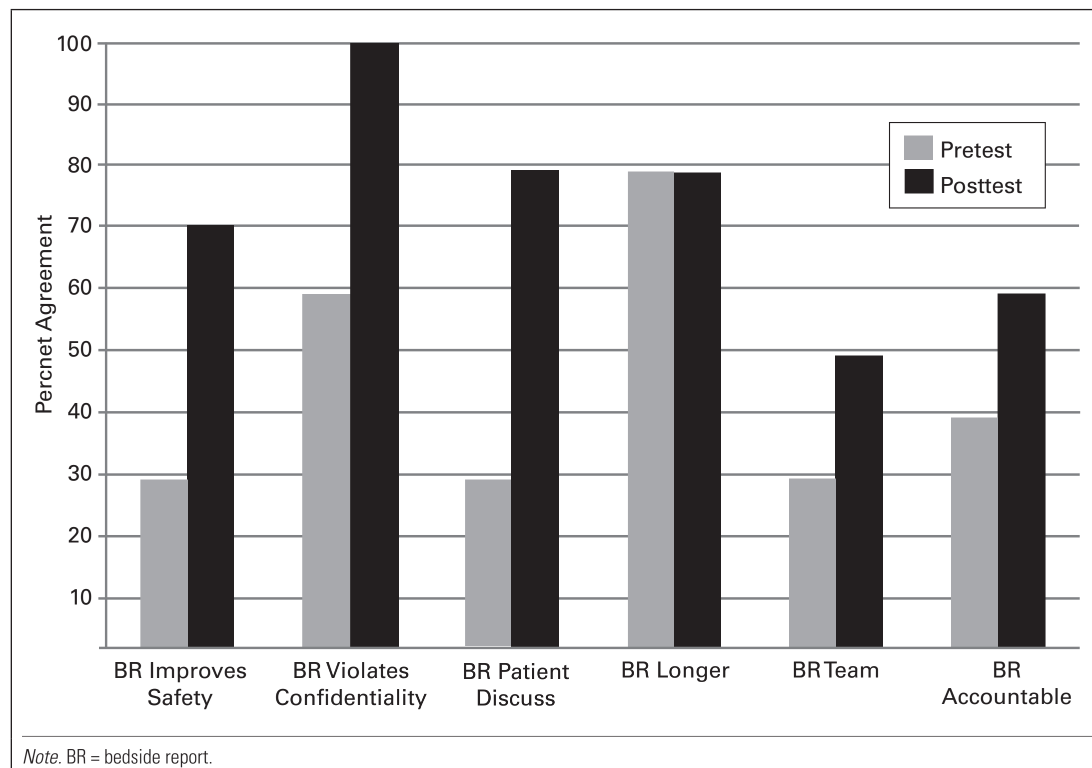
The next step to implementing bedside reporting on the stroke rehabilitation unit was to build a team. This included the support of administration, which was already established, as well as identifying nurses on the unit willing to help develop bedside reporting guidelines. A literature review on bedside reporting provided the nurses with many recommendations; however, their preferences for some of the guidelines were also established. For example, they decided only licensed staff would participate in bedside reporting and unlicensed staff would receive a report afterward.

To ensure data consistency and facilitate an atmosphere of patient-focused care, nurses conducted bedside reporting during shift change using a standardized reporting tool (a reporting sheet) as a source of patient data. The nursing staff were asked to develop a report sheet that would meet the goals of the new reporting method, which were to shorten report time and make reports more patient focused. The report sheets were revised to list problems and relevant patient information. For example, for a patient who has experienced a stroke, his or her first problem might be listed as "Safety: Bed alarm device." The nurse's verbal report at the bedside mainly focuses on variances or patient problems. The report includes the nursing care provided, the patient's current condition, and the patient's care needs during the next shift. Most importantly, the patient is encouraged to participate in the information being communicated. Keeping the patient informed and at the center of all decisions regarding care is essential to meeting the goals of bedside report.

Education for Patients and Staff

Education for patients and nursing staff took place the week before bedside reporting was initiated and was completed using several methods. In-service education was presented to nurses during the change of shift and was accompanied by a handout highlighting the main ideas. These included the purpose or shared vision, contributing factors, benefits, and the report-process guidelines. It should be noted that the new standardized reporting tool to be used during bedside reporting was introduced and used by nurses the week before bedside reporting was implemented. The new process for shift reporting became a priority; however, nurses needed to be familiar with the new report sheet as well. Providing staff with a period of time to become accustomed to the report sheet proved beneficial when bedside reporting was initiated.

Figure 2. Postimplementation Survey Results 4 Months After BR Initiation



Note. BR = bedside report.

In addition to the in-service education and handouts, a manual on bedside reporting was designed for staff to reference. The manual not only included content from the in-service education, but also multiple articles on shift and bedside reporting, a copy of the Nursing Partnership Model, the patient letter, and an information sheet about confidentiality from the U.S. Department of Health and Human Services Web site (www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html).

Patient education was provided to all patients through a welcome/education letter as well as a brief informal presentation. Staff would reinforce the purpose of the new reporting process and encourage patient participation during the change-of-shift report.

Evaluation

The bedside-reporting process was implemented despite initial challenges. Educating nursing staff before the bedside-reporting process was implemented was essential to establish support and buy-in among the staff. The support and enthusiasm of the unit manager and nursing director were significant because during the initial phase, education was provided during scheduled meeting times when resistance among staff was highest.

A postimplementation survey was administered to nurses 4 months after bedside reporting was initiated. The results (**Figure 2**), which were shared with the nurses at staff meetings, showed that most of the nurses felt the new reporting method had improved patient safety and provided patients with an opportunity to discuss their plan of care. In addition, the survey indicated that nurses felt this type of hand off made off-going staff more accountable and reassured patients that the nurses worked as a team. Anecdotal written comments from the nursing staff also indicated nurses felt the new report sheet gave them necessary information to care for their patients.

However, nurses also identified areas for improvement. They found that bedside reporting works best at the start of the day and evening shifts. Night shift staff use the new report sheet, though they record their verbal reports away from the bedside so that sleeping patients are not disturbed. The need for a short report time away from the bedside was also identified when discussing sensitive issues; therefore, a postreport time was established on an as-needed basis. Confidentiality remained a concern for some nurses despite being informed that discussing a patient's case is an acceptable practice for nurses as well as physicians.

The biggest challenge encountered in implementing bedside reporting was encouraging patients to be part of the discussion. Because traditional change-of-shift reporting took place away from the bedside, many nurses were initially unsure of how to best engage the

patient in bedside reporting. However, using "champions" or nurses who were adept in communicating the plan of care with patients helped ensure that all nurses quickly became comfortable with the new process.

Conclusion

Bedside reporting provides nurses with an opportunity to improve patient safety and increase patient collaboration in the plan of care. There is also less concern related to inaccurate or lack of information because the report process includes actual patient visualization. Increased staff satisfaction with bedside reporting encourages teamwork and promotes accountability. When reporting is finished, nurses feel they are aware of the issues their patients are experiencing, which enables them to plan and prioritize nursing interventions. The communication process at the bedside meets the needs of both the patient and the nurse and is a win-win situation for all.

Acknowledgments

The authors would like to acknowledge the nursing staff on 7C for their efforts in making this project a success.

About the Authors

Dawn Laws, BSN RN CRRN, is the manager of the stroke rehabilitation unit at MetroHealth Rehabilitation Institute of Ohio, Cleveland, OH. Address correspondence to her at dlaws@metrohealth.org.

Shelly Amato, MSN RN CNS CRRN, is a clinical nurse specialist in brain injury/stroke rehabilitation at MetroHealth Rehabilitation Institute of Ohio, Cleveland, OH.

References

Anderson, C. D., & Mangino, R. R. (2006). Nurse shift report: Who says you can't talk in front of the patient? *Nursing Administration Quarterly, 30*(2), 112–122.

Caruso, E. M. (2007). The evolution of nurse-to-nurse bedside report on a medical-surgical cardiology unit. *MedSurg Nursing, 16*(1), 17–22.

Greaves, C. (1999). Patients' perceptions of bedside handover. *Nursing Standard, 14*(12). 32–35.

Hays, M. M. (2003). The phenomenal shift report: A paradox. *Journal for Nurses in Staff Development, 19*(1), 25–33.

Johnson, M., & Web, C. (1995). Rediscovering unpopular patients: The concept of social judgment. *Journal of Advanced Nursing, 21*, 466–475.

Joint Commission on Accreditation of Health Care Organization (JCAHO). (2000, July). Sentinel event alert: Fatal falls. Retrieved January 14, 2010, from www.jointcommission.org/SentinelEventAlert/sea_14.htm.

Jordan, P. (1991). Psychiatric unit handovers. *Nursing Times, 87*(43), 40–42).

MetroHealth Medical Center. (2002). *The Partnership Model: MetroHealth Nursing Service Standards Manual*. Cleveland, OH: Author.

Mosher, C., & Bontomasi, R. (1996). How to improve shift report. *American Journal of Nursing, 96*(8), 32–34.

Potter, P., & Mueller, J. R. (2007). How well do you know your patients? *Nursing Management, 38*(2), 40–48.

Priest, C. S., & Holmberg, S. K. (2000). A new model for the mental health nursing change of shift report. *Journal of Psychosocial Nursing and Mental Health Services, 38*(8), 36–43.

Richard, J. A. (1989). Walking rounds a step in the right direction. *Nursing, 19*(6), 63–64.

Schoolfield, M., & Orduña, A. (2001). Understanding staff nurse responses to change: Utilization of a grief-change framework to facilitate innovation. *Clinical Nurse Specialist, 15*(5), 224–229.

Schroeder, S. J. (2006). Picking up the PACE: A new template for shift report. *Nursing, 36(*10), 22–23.

Strople, B., & Ottani, P. (2006). Can technology improve intershift report? What the research reveals. *Journal of Professional Nursing, 22*(3), 197–204.

Earn nursing contact hours

Rehabilitation Nursing is pleased to offer readers the opportunity to earn nursing contact hours for its continuing education articles by taking a posttest through the ARN Web site. The posttest consists of questions based on this article, plus several assessment questions (e.g., how long did it take you to read the article and complete the posttest?). A passing score on the posttest and completion of the assessment questions yield one nursing contact hour for each article.

To earn contact hours, go to www.rehabnurse.org and select the "Education" page. There you can read the article again, or go directly to the posttest assessment by selecting "*RNJ* online CE." The cost for credit is $10 per article. You will be asked for a credit card or online payment service number.

The Association of Rehabilitation Nurses is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation (ANCC-COA).