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The Move from Recorded to Bedside Shift Report: Evaluating Barriers to Full Implementation

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This is to certify that the doctoral study by

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Abstract

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MSN, St. Louis University, 1996

BSN, Indiana University of PA, 1985

Project Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Many sentinel events in acute care centers can be attributed to miscommunication of patient information at shift change. A growing body of evidence supports the implementation of bedside shift report as the standardized approach to ensure effective communication by staff. The purpose of this study was to identify the barriers that impede nurses from fully participating in bedside shift report in order to create an educational initiative to develop the nursing staff's proficiency in performing bedside report. Lewin's change theory served as the framework for the project. Data for the staff development project were collected using a focus group approach with 18 nurse participants. A classic method of analysis, defined and outlined by Krueger and Casey (2009), was used to identify themes and categorize results. A second evaluator of the data supported thematic findings. Nurses revealed barriers consistent with the literature including frequent interruptions, patient confidentiality, sensitive issues, and inconsistent report content. Barriers identified by this study, but not evident in the reviewed literature, included staff unavailability to answer call lights and having to receive report and transfers during report. An education plan was developed based on perceived barriers and evidence in the literature. Implications for positive social change include interventions to refine the current practice of bedside shift report in order to promote effective and efficient communication at change of shift. Findings can inform nursing units in the hospital and other facilities to achieve patient-centered care and improved outcomes. It is critical that nurses understand the positive impact that consistent, timely, and effective shift reports have on providing safe, quality patient care.

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Dedication

This project is dedicated to all the nurses on the telemetry unit who want to provide safe, quality, and evidence-based patient care. It is also dedicated to my husband and three daughters who endured and endless stream of paper and books on the dining room table for the last year and a half. Thank you for your patience and your unwavering support.

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I would like to thank my preceptor who inspired confidence in me as a nurse, clinical specialist, scholar, and leader. To Dr. Vitale, whose commitment to genuinely wanting to make us scholarly practitioners, thank you. To my family, thank you for tolerating the endless array of papers and books covering the dining room. I never would have made it through without you.

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Section 1: Nature of the Project

Introduction

Change-of-shift report has been described as the transfer of essential patient information and the responsibility of patient care between nurses coming on shift and nurses completing their shift (Jeffs et al., 2013). There have been various methods of shift report used over the years, from verbal report outside the patient room or in a conference room, to taped report, to a combination of taped and verbal report (Caruso, 2007).. Regardless of the report method, the literature is consistent regarding the problems associated with change-of-shift report. These problems include a lack of report consistency and structure, potential failures in communication leading to adverse events, and not providing the opportunity for the patient to be included in the plan of care (Cairns, Dudjak, Hoffmann, & Lorenz, 2013). The Joint Commission (TJC) estimated that 65% of sentinel events were the result of communication problems, especially during change of shift report (Cornell, Townsend-Gervis, Yates, & Vardaman, 2013). This prompted the TJC to require a standardized method of shift report as part of the National Patient Safety Goals.

Researchers have supported the use of bedside shift report. Active patient participation in hospital care is shown to result in better health outcomes and places the patient central to information related to care activities (Jeffs et al., 2013). Radtke (2013) reported that bedside report improves communication between nurses, patients, and their families and provides for "patient-focused care and the application of evidence-based care at the bedside" (p. 19). Bedside report serves other functions beyond effective

communication. The nurse can better give the patient the opportunity to be involved in his or her care, perform quality and safety checks, check for misinformation, and ask final questions to ensure continuity of care (Halm, 2013). Petersen, Blackmer, McNeal, and Hill (2013) identified two positive evidence-based behaviors from their study surveying staff nurses: checking the patient during handover and patients being involved in the handover process. Clearly the literature supports bedside shift report as a means of communication that is beneficial for both the patient and the nurse.

A local community hospital phased out a taped system for change-of-shift report. The chief nursing officer (CNO) established an organizational goal for all nursing units to participate in bedside shift report as part of patient- and family-centered care (C. Cioffi personal communication, October 6, 2014). An 18-bed telemetry unit implemented bedside shift report in July 2014. This clinical specialist and unit manager observed nurses on the unit struggle with giving full report at the patient's bedside as evidenced by the nurses standing outside the patient rooms and sitting at the work stations during the shift change report.

Problem Statement

Researchers have supported moving change-of-shift report to the patient's bedside to improve patient safety and quality outcomes (Dufault et al., 2010; Jeffs et al., 2013; Riesenberg, Leitzsch, & Cunningham, 2010; Sand-Jecklin & Sherman, 2013). The organization under study has set a goal that all units will participate in bedside shift report by the end of fiscal year 2015. Nurses on the telemetry unit were trained in implementing the change from recorded report to report at the patient's bedside in the

summer of 2014. The telemetry unit manager chose to pursue the implementation of bedside report before the CNO announced that all units would be required to convert. In observations, the manager and clinical specialist of the telemetry nursing staff during change-of-shift report indicated that evidence-based bedside shift report was not being carried out effectively or as iterated by the organizational leadership. It was unknown what barriers were keeping the nurses from performing report at the bedside. These barriers to implementation had to be identified in order to develop the necessary education and skills training for nurses to capably and confidently perform bedside shift report.

Purpose Statement

The purpose of the project was to identify what the nurses for this telemetry unit perceive as barriers to performing change-of-shift report at the patient's bedside. Several barriers to giving report at the bedside have been identified in the literature. Most of the barriers center around the nurses being uncomfortable in front of the patients, having a lack of confidence, and fear of breaching patient confidentiality (Evans, Grunawalt, Laws & Amato, 2010; McClish, Wood, & Friese, 2011; Sand-Jecklin & Sherman, 2013). Additional barriers include (a) not knowing about sensitive topics that may not have been addressed by the doctors (eg., test results), (b) overtime (Griffin, 2010; Sand-Jecklin & Sherman, 2013), (c) talk and questioning from the patient that would lengthen report (Anderson & Mangino, 2006), and (d) patients asking for things which impede the progress of report (Evans et al., 2011). Barriers identified in the literature may or may not be consistent with barriers experienced by the nurses on the identified telemetry unit.

The change in practice from recorded to bedside shift report on the telemetry unit was ineffective. Kelly (2011) stated that in order for change efforts to be sustained, behaviors "below the waterline" must be targeted (p. 35). On the surface, the telemetry nurses are not performing bedside report as designed by the organization. To better understand this behavior, perceived barriers must be identified, brought to the surface, acknowledged, and acted upon to bring about and maintain the desired change.

Goals and Objectives

In the project, I focused on determining what barriers this unit perceives regarding performing report at the patient's bedside at the change of shift. TJC (2007) first addressed effective hand-off communication in the 2006 National Patient Safety Goals (NPSG) where the emphasis was providing accurate information that included an opportunity for nurses to ask and respond to questions. As of 2013, TJC (2013) added bedside shift report as an important practice to keep the patient and family informed for safe continuity of patient care. Nurses performing change-of-shift report at the patient's bedside can fulfill compliance with these requirements and the organization's strategic goal of patient- and family-centered care.

At the start of the project, approximately half of the hospital units were using an automated form of recorded report at change-of-shift and when a patient is transferred from one level of care to another. In the following months, this automated recorded report was no longer available for the staff to use at any care transition point. The results of this project will be used to refine the report process on the telemetry unit but can also provide information to other units as they plan implementation and evaluation of bedside

shift report. In addition, the results will be used to develop an educational initiative that addresses the identified barriers to performing shift report at the bedside.

Theoretical Foundation

Implementing change in health care can be challenging due to the complex nature of the environment (Anderson & Mangino, 2006). Sustaining the change can be even more challenging. Lewin's (1947) change theory served as the framework for this project. Several researchers used this theory to guide the change of implementing bedside shift report (Caruso, 2007; Chaboyer et al., 2009; McMurray, Chaboyer, Wallis, & Fetherston, 2010; Radtke, 2013). There are three phases of this model: unfreezing the current behavior, moving or changing the behavior, and refreezing or stabilizing the change (Kritsonis, 2005). Kritsonis (2005) added that the change will not be sustained without refreezing. White and Dudley-Brown (2012) agreed that a "refreezing" of the new process must take place after implementation. Lewin also described driving forces that encourage the change or restraining forces that keep it from happening (Lewin, 1947). This model is effective to use for this project because the barriers that keep bedside shift report from being fully implemented must be identified for the change to be sustained.

Nature of the Project

This project provided the opportunity to evaluate and possibly refine the process of bedside shift report on the telemetry unit. Evidenced-based literature application and a focus group approach were used to explore the perceived barriers and concerns of the nurses in reaching full implementation of bedside shift report on the telemetry unit. The

focus group approach provided the opportunity to determine the general attitude of the unit staff regarding the change in practice (Grove, Burns, & Gray, 2013). For the project, a convenience sample of nurses on the telemetry floor was recruited to comprise four focus groups.

The purpose of the focus groups was to elicit from the nurses their perceived advantages (driving forces) and barriers (restraining forces), and what still needs to be developed, to ensure that bedside shift reporting is successfully maintained. The qualitative information was used to develop change management strategies and education sessions, such as case studies and role playing, to address barriers and concerns the nurses express in the focus group and to increase their confidence and compliance with reporting at the bedside (Cairns et al., 2013).

Significance of the Project

As a patient safety strategy, TJC assesses hospitals for a mechanism of change-of-shift report that allows for the nurses to ask and respond to questions and for patients and families to be informed through shift report at the patient's bedside (TJC, 2013). The organization under study requires all units in the hospital to perform bedside shift report as one element of the strategic goal of patient- and family-centered care. Identification of barriers to full implementation of bedside shift report on the telemetry unit will inform unit staff and leadership and serve as a guide for developing change management strategies and education sessions focused on refining the process of reporting at the bedside. In addition, the results can inform the other units as they plan the implementation of bedside shift report on their units.

Implications for Social Change

The American Association of Colleges of Nurses (AACN, 2006) indicated that the Doctor of Nursing Practice (DNP) graduate must be skillful in quality improvement initiatives that not only create evidence-based changes, but also maintain those changes for improved outcomes and patient safety. Identified behaviors not readily visible that impede full implementation of bedside shift report on the telemetry unit will be used to guide and facilitate interventions to refine current practices on the unit and benefit other units as they evaluate the implementation of report at the bedside. This project involved the evaluation of a practice issue in order to promote effective and efficient patient-centered care (AACN, 2006). This project added to the knowledge of barriers to maintaining effective bedside shift report that can benefit the entire organization and other organizations that are struggling with the same practice issue.

Definitions of Terms

The following definitions were used to guide this project.

Barrier: Obstacle to a change process (McMurray et al., 2010).

Change-of-shift report: A term used synonymously with handoff and shift report, change-of-shift is the transfer of information, authority, and responsibility (Friesen, White, & Byers, 2008) from the off-going nurse to the on-coming nurse with the opportunity to ask questions and clarify information (Cairns et al., 2013). The term is synonymous with handoff and handover.

Evidence: Research findings, knowledge from science, clinical knowledge, and expert opinion (Youngblut & Brooton, 2001).

Level of care change: Movement that patients make between hospital nursing units when their care needs change during acute illnesses (Friesen et al., 2008).

Patient- and family-centered care: An approach to health care that centers on relationships and collaboration between patients, their families, and health care practitioners. Patients and families are encouraged to participate in care and in decision making about their care (Tidwell et al., 2011).

Patient safety strategy: Promotion of a patient safety culture using leadership, teamwork and behavioral change (Weaver, Lubomksi, Wilson, Pfoh, Martinez, & Dy, 2013).

Practice issue: Any situation that puts the patient at risk or affects the nurse's ability to provide care in line with standards, guidelines, policies, or procedures (College of Registered Nurses Nova Scotia (CRNNS), 2012).

Telemetry unit: Nonintensive, monitored nursing care unit for patients at lower risk than those requiring care in the intensive care unit (Hollander, Valentine, McCuskey, & Brogan, 1997).

Assumptions and Limitations

Assumptions

Assumptions are statements that are thought of as true by the researcher and peers even though they are not scientifically tested (Grove et al., 2013). This project included the following assumptions:

- Nurses on the telemetry unit received initial training on bedside shift report

- Nurses on the telemetry unit understand that bedside shift report is an organizational goal
- Nurses on the telemetry unit will be willing to participate in the project
- Nurses will discuss and answer questions honestly during the focus groups

Limitations

Limitations are potential influences that the researcher does not have control over but can affect generalizability of the study (Grove et al., 2013). The current project includes several limitations:

1. The barriers identified by the telemetry unit staff may not be comprehensive.
2. The barriers identified by the telemetry unit may not be generalizable to other units in the hospital.
3. The barriers identified by the telemetry unit will not be generalizable to other hospitals.
4. I am employed at the hospital where the project is being implemented. This may influence volunteers for the focus groups who are acquainted with the student and may influence their responses to the questions.
5. Volunteers are asked to participate in the focus group on personal time; therefore, scheduled work conflicts may limit participation from this specific population of nurses.

Summary

In this section, I presented a brief overview of the problem that an 18-bed telemetry unit is experiencing after implementation of bedside shift report. Although the nurses were trained in performing bedside shift report, they are observed reporting away from the patient's bedside. In order to sustain the change in practice from recorded to bedside report, restraining forces that keep the change from happening must be identified and addressed. These barriers will serve as a guide to develop interventions and education sessions to refine the bedside shift report process.

In Section 2, I present a literature review and discussion of the change theory framework that guides the quality improvement project. Initial discussion will focus on an introduction to the form of nursing communication known as shift report. Supportive literature on bedside shift report will follow with an emphasis on safety, effectiveness, and accountability; patient and nurse satisfaction; patient- and family-centered care; and aligning with change theory.

Section 2: Review of the Scholarly Literature

Introduction

The purpose of this project was to identify what barriers nurses on a telemetry unit perceive to be impediments to performing change-of-shift report at the patient's bedside. In order to achieve sustainability of the change in practice from a recorded report to bedside report, the restraining forces need to be identified, acknowledged, and acted upon. In Section 2, I will present a synthesis of the scholarly literature describing the significance of the practice issue, the relevance of bedside shift report including patient safety and patient and nurse satisfaction, identified barriers to performing bedside report, and the role of this type of report in patient- and family-centered care. This section will conclude with a review of the change theory to be used as the framework for this project.

Literature Search Strategy

The literature search was conducted electronically using CINAHL, Medline, ProQuest, and OVID databases. Terms used to search for the literature were *handoffs*, *nursing handoffs*, *shift report*, *change-of-shift report*, *nursing report*, *bedside shift report*, *bedside handoff*, *adverse events*, *patient safety*, and *patient- and family-centered care*. The initial search provided 45 articles. Articles were discarded if they did not contain relevant information related to the topic of interest. In order to obtain a larger number of articles, the Boolean search terms and" and "or" were used between words. A final total of 30 articles were selected as most relevant. Articles were then grouped by the following common themes: nursing handoffs/shift handoffs, bedside report and

accountability/patient safety, bedside report and patient-and family-centered care, nurse and patient satisfaction related to bedside report, barriers to bedside shift report, and change theory as it relates to bedside shift report.

Shift Reporting in Nursing

Nursing Communication

Communicating accurate and timely patient information is essential in providing safe and quality patient care and ensuring continuity in each patient's care. This is especially true of nursing's change-of-shift report. Caruso (2007) described shift report as a time for attentive communication about the patient to ensure safety and continuity of care; yet, this communication rarely includes the patient. According to Halm (2013), approximately 2.9 million change-of-shift reports take place annually in hospitals with an average daily census of 400 and nurses working 12-hour shifts. This frequent transfer of patient data is often cited as contributing to errors, care omissions, treatment delays, repeated work, inappropriate treatment, adverse events, increased length of stay, avoidable readmissions, and increased costs (Cairns et al., 2013; Halm, 2013; Jeffs et al., 2013; Riesenberg et al., 2010).

Change-of-shift report can take on a variety of forms. Welsh, Flanagan, and Ebright (2010) conducted a qualitative, descriptive pilot study to characterize handoff procedures for nurses at change-of-shift using two types of handoff, taped and written. A convenience sample of nurses from three inpatient units of a Midwestern veteran's administration medical center participated in semistructured interviews. Data analysis consisted of a grounded theory approach in which two investigators coded the data into

"barriers," "facilitators," and "other" categories (p. 149). Themes were then generated and legitimized using a nursing subject matter expert. Six barriers and four facilitators were revealed as displayed in Figure 1.

Barriers	Facilitators
Incomplete report	"Pertinent" content
Incomplete with non-essential information	Ability to ask questions of off-going nurse
Differing quality between nurses	Report tool in checklist format
Unable to clarify information or ask questions	Ability to take notes while listening
Equipment malfunction	
Interruptions	

Figure 1. Barriers and facilitators adapted from Welsh, C. A., Flanagan, M. E., & Ebright, P. (2010). Barriers and facilitators to nursing handoffs: recommendations for redesign. *Nursing Outlook*, *58*(3), 148-154.

The investigators concluded that even though the study is not generalizable because the sample is not representative, the findings are consistent with other studies and indicate that these issues with written and taped report are common in acute care facilities (Welsh et al., 2010). Anderson and Mangino (2006) add that these traditional methods of shift report allow for minimal communication between nurses and can ultimately have a negative impact on patient safety related to incomplete information being relayed.

Potential for Errors and Adverse Events

Ineffective change-of-shift report can result in compromised patient safety. TJC estimated that 65% of sentinel events were the result of communication problems, especially during change of shift report (Cornell et al., 2013). The Agency for Healthcare Research and Quality (AHRQ, 2009) surveyed 176,811 hospital staff on patient safety culture. Almost half of the respondents (49% and 45% respectively) indicated that "important patient care information is often lost during shift changes," and "shift changes are problematic for patients in this hospital" (AHRQ, 2009, p. 39). Nurses on the telemetry unit have reported not receiving important patient information during shift report consistent with the AHRQ (2009) survey (S. Moore, personal communication, October 10, 2014).

Miscommunication of patient information at shift change is responsible for almost two- thirds of sentinel events in acute care centers (Cairns et al., 2013; Dufault et al., 2010). Consequently, TJC (2008) now requires a standardized approach to handoff communications, including an opportunity for the staff to ask and answer questions. TJC (2008) launched a National Patient Safety Goal as a patient safety strategy encouraging patients to get involved in their care. Researchers support the implementation of bedside shift report as that standardized approach to ensure effective communication by staff (Dufault et al., 2010; Jeffs et al., 2013; Sand-Jecklin & Sherman, 2013).

Variability in the way that report is accomplished may also introduce errors and potential adverse events (Riesenberg et al., 2010). In a quasi-experimental study, Pothier, Monteiro, Mooktiar, and Shaw (2005) simulated handover scenarios testing three

different types of shift report styles: verbal only, written only, and a combination of written and verbal. In this study, Pothier and colleagues reported that the nurses retained the patient information with the combination of written and verbal report (96-100%), while they did not for verbal only (0-22%) and written only (26-49%). Regardless of which method of report is used, strengths and weaknesses are inherent to all methods (Friesen et al., 2008). Thousands of patients are cared for in hospitals each day so there are thousands of opportunities for mistakes (Baker, 2010), especially when it comes to the transfer of patient information.

Movement to Bedside Shift Report

Traditional methods of shift report do not allow for the patient to become involved in this communication of information. Anderson and Mangino (2006) described driving forces that have led nursing to move shift report to the patient's bedside. Easy access to the Internet has given patients medical information that they were not previously exposed to, giving them more knowledge to make decisions about health care. This knowledge has prompted a change to a more collaborative model of care instead of physicians having exclusive rights over how patients' care is managed (Anderson & Mangino, 2006). This extends to the acute care setting. Maxson, Derby, Wrobleski, and Foss (2011) expressed that when patients are given the opportunity to participate in bedside report, they are more likely to contribute to their plan of care and to be kept informed of their condition. In addition, bedside change-of-shift report provides an opportunity for nurses to address some of the inefficiencies associated with traditional methods of taped and verbal shift report (Anderson & Mangino, 2006).

Background of Bedside Shift Reporting

Nursing shift report traditionally has been performed away from the patient's bedside where the patient and family are not actively involved in the information exchange or even aware that the exchange is taking place (Kerr, Lu, & McKinlay, 2013; Maxson et al., 2011). Today, there is more of an inclusive approach to health care where patients are actively involved in the decision-making process (McMurray et al., 2010). Many hospitals are redesigning their current shift report practices to meet the standards set forth by TJC (Welsh et al., 2010). Moving shift report to the patient's bedside not only allows the oncoming nurse to visualize the patient, but to ask questions of the previous nurse and encourage participation of the patient into the plan of care (Maxson et al.).

The concept of bedside shift report is not new. Greaves (1999) stated that at the turn of the century, the ward (unit) sisters in England would make rounds with the night nurse on each of the patients to check that standards of care were met through the night. Greaves discussed that this was a "one way" communication including instructions to the nurse (p. 32). Pepper (1978) challenged nurses to vacate traditional report taking place away from the patient's bedside, usually in a conference room. Pepper stated that a benefit of giving report at the patient's bedside is the ability of the nurse to include the patient in their care and decisions about their care. According to Pepper, this patient-centered approach to shift report should be accomplished every shift; otherwise, the patient may perceive this as just a daily "exercise" by the nursing staff (p. 74). Telemetry

unit nurses are observed performing change-of-shift report away from the patient's bedside, which does not allow for patient involvement in planning daily care.

There are a variety of ways that shift report is practiced when transferring the responsibility and accountability of patient care from one nurse to another. This variability increases the risk for missed or incorrect patient information, thereby jeopardizing patient safety (Alvarado et al., 2006). Street et al. (2010) used a cross-sectional survey to ascertain the strengths and limitations of current handover before implementing a new bedside handover process. Street et al. emphasized the significant variations in their current practice, which included the duration of the handover, method, and location where the information was exchanged. Handover at the bedside allowed for patient and family involvement, which could improve handover effectiveness and patient safety (Street et al., 2010). The current practice of shift report on the telemetry unit varies between nurses. Shift report from some nurses have been described as thorough yet timely, while others are described as lengthy with irrelevant information.

Bedside shift report can increase teamwork on the unit and accountability of the staff and is directly related to TJC's National Patient Safety Goals (TJC, 2008), including Goal 13: to involve the patient in their care as a strategy to improve patient safety (Baker, 2010). In a qualitative study in an inner city, acute care teaching hospital, Jeffs et al. (2013) reported two major themes surfaced while interviewing 43 registered nurses after the implementation of bedside shift report. The two themes, "clarifying information and intercepting errors" and "visualizing patients and prioritizing care," are reflective of the

safety benefits and accountability that accompany bedside shift report (Jeffs et al., p. 229-230).

Patient- and Family-Centered Care

There is a focus in the literature on patient- and family-centered care, which highlights collaboration and developing partnerships between the patient, their family, nurses, and other health care providers (Tidwell et al., 2011). According to Tidwell et al. (2011), one way that nurses can promote this collaboration is by encouraging patients and families to participate in change-of-shift report at the bedside. Griffin (2010) affirmed that sharing patient information at the bedside allows the patient and family to engage in the care and decision-making process at the level they choose to participate, which improves the experience of the patient.

Patients identify several benefits of bedside shift report. In a pilot study to explore patient perceptions of bedside shift report, Friesen, Herbst, Turner, Speroni, and Robinson (2013) surveyed and interviewed patients to determine potential areas for improvement in their report process. A qualitative analysis was conducted on the interview responses in which the researchers identified five themes. First, patients felt the introduction of the new nurse coming on shift was important and left them feeling reassured (Friesen et al., 2013). Second, patients observed communication and collaboration during the shift report (Friesen et al., 2013). Third, the sharing of information during report at the bedside assisted patients in knowing what was being communicated to the next shift (Friesen et al., 2013). Knowing what is communicated is one of the crucial concepts in patient- and family-centered care. The fourth theme

addressed the patient's perspective: educating health care providers. The patients adopt the role of educator by informing the nursing staff what works best regarding report at the bedside, like using a wipe board to write information the patient wants to know (Friesen et al., 2013). Finally, the fifth theme, managing privacy, was acknowledged by the patients as challenging with both hard-of-hearing patients and sensitive topics (Friesen et al., 2013). Removing the barriers that restrict the patient from participating in bedside shift report is imperative in order to give the patients the opportunity to know.

Both patients and nurses identify benefits of performing change-of-shift report at the patient's bedside. In a mixed methods study, Sand-Jecklin and Sherman (2013) used anonymous surveys of patients and nurses to evaluate the processes and outcomes of moving from a recorded change-of-shift report to a combination of recorded and bedside report. To survey the patients, Sand-Jecklin and Sherman used an adapted Patient Views on Nursing Care instrument. The survey was both preimplementation (n=232 patients) and postimplementation (n=178 patients). Sand-Jecklin and Sherman found significantly higher scores on "made sure I knew who my nurse was," "include in shift report discussion," and "communicated important information about care" (p. 190). The Nursing Assessment of Shift Report instrument developed by Sand-Jecklin and Sherman was used to survey the nurses using the same pre-post implementation design. Sand-Jecklin and Sherman revealed significant improvement after implementation in several areas including effective and efficient means of communication, ensuring accountability, and promoting patient involvement in care.

Patient and Nurse Satisfaction

Bedside shift report serves a number of different functions beyond the transfer of essential patient information, two of which are patient and nurse satisfaction. Vines, Dupler, Van Son, and Guido (2014) conducted a literature review to determine if bedside report promoted patient and nurse satisfaction. Although 95 publications were retrieved, the results were limited by date (2006 and later), hospital setting (acute), and relevance to the proposed purpose, leaving nine articles for review. Vines et al. concluded that the evidence supports using report at the bedside for change-of-shift handovers in an adult acute care setting. In addition, improvements were determined in patient and nurse satisfaction throughout the studies (Vines et al., 2014). Regardless of the supportive evidence for using bedside shift report, nurses on the telemetry unit continue to report away from the patient's bedside.

Standardizing bedside shift report can positively impact patient satisfaction. The objective of a study by Radtke (2013) was to determine if standardizing shift report to the bedside improves patient satisfaction, specifically in the realm of nursing communication. Prior to bedside report, the score for communication with nurses was 75% (Radtke, 2013). Bedside shift report was implemented on a 16-bed medical/surgical intermediate care unit (Radtke, 2013). Staff was interviewed 1 week after implementation, and patients were interviewed at 1 week and continued through a 3-month time period (Radtke, 2013). Staff gave positive feedback about understanding their patients' needs and able to plan around these needs. Patient satisfaction survey results increased from 75% satisfaction in nursing communication to 87.6% (Radtke, 2013). It was noted that

they did not reach their goal of 90%; however, the change in practice did result in a significant increase in this area of patient satisfaction (Radtke, 2013).

Patients and nurses identify the benefits of bedside shift report. Maxson et al. (2011) conducted a study to determine if bedside shift report increased patient satisfaction and patient perception of teamwork. A second purpose was to determine if bedside shift report increased staff satisfaction with communication and accountability. Both the staff and patients agreed to participate in the surveys that took place before the implementation of bedside shift report and 1 month after. Maxson et al. revealed statistically significant increases in patient perception of their involvement in the plan of care (p=0.02) and nurses' perceptions regarding accountability (p=0.0005), medication reconciliation (p=0.0003), and ability to immediately communicate concerns with physicians (p=0.008). Anecdotal responses from patients and nurses substantiated the importance of the change in practice (Maxson et al., 2011, p. 142).

Sustaining Change

Lewin's (1947) change theory served as the framework for several studies when implementing bedside shift report. McMurray et al. (2010) concluded that in order for change to be successful, those managing the change must be aware of nurses' attitudes, concerns, and level of confidence, especially in the case of communicating in bedside shift report. Caruso (2007) described the stages of change that guided implementation of bedside report, but also gave the change team an understanding of the change process including being able to address potential challenges before the actual change took place.

Radtke (2013) supported these findings stating that one lesson learned from a pilot bedside report process was to identify potential barriers before the intervention began.

Vines et al. (2014) used Lewin's change theory to develop an educational initiative for staff regarding bedside shift report and provided recommendations for sustaining the initiative as part of everyday nursing practice. Olson-Sitki, Weitzel, and Glisson (2013) used this change model to address collapse of the bedside report process initiated just months earlier. In the unfreezing stage, the focus was engaging staff to recognize the need for the change and to overcome the resistance to maintaining the use of bedside report (Olson-Sitki et al., 2013)). Olson-Sitki et al. re-examined the original implementation of the report process and were able to identify the restraining forces and subsequently develop a plan to move forward with a sustained change in practice. In order to sustain the change in practice to bedside shift report, the restraining forces for the telemetry nurses must be identified so that a plan can be developed to overcome areas of resistance.

Barriers to Bedside Shift Report

Nurses still struggle to fully implement shift report at the bedside even with emerging newer evidence about the importance of actively involving the patient in bedside shift report (Sand-Jecklin & Sherman, 2013). Breaching confidentiality has been frequently cited as a significant barrier in the literature. Nurses are concerned with Health Insurance Portability and Accountability Act (HIPAA) violations and patient privacy when other patients or families are in the room (Anderson & Mangino, 2006; Cairns et al., 2013; Evans et al., 2012; Sand-Jecklin & Sherman; and Radtke, 2013).

Nurses report fears and apprehensions not only about confidentiality, but also bringing up sensitive issues such as test results the physician had not yet discussed with the patient, complicated family dynamics, and having to discuss treatment noncompliance with the patients (Cairns et al., 2013).

The time commitment to complete report is a concern expressed by nurses as a barrier; however, there is limited literature that addresses the length of time difference between bedside report and traditional methods. Cairns et al. (2013) reported a decrease in end-of-shift overtime by 10 minutes per day, or 61 hours per year, representing a cost savings of 23% of the unit's budget. Tidwell (2011) and colleagues discussed a decrease of almost 250 hours of overtime in a 7-month period of time after implementing bedside shift report, representing a statistically significant decrease. Anderson and Mangino (2006) referenced a decrease in time over shift of 100 hours each pay period over two consecutive pay periods. In one of the only studies to report specific time increment changes, nurses revealed that bedside report averaged 5-7 minutes which was less than their pre-implementation verbal report at the nurse's station (Caruso, 2007). In most cases, nurses were concerned that patients would talk too long, ask too many questions, or ask for something during report, hence, lengthening the report time (Anderson & Mangino, 2006; Evans et al., 2011; and Sand-Jecklin & Sherman, 2013). Street et al. (2011) added "frequent interruptions" and "nurses chatting during handovers" as barriers to bedside shift report (p. 139).

Theoretical Framework Literature

Lewin's Change Theory

Lewin's model describes a force field where driving forces and restraining forces exist. Driving forces are "forces toward" something or "forces away from" something, while "restraining forces," on the other hand, oppose the driving forces (Lewin, 1947, p.28). Lewin (1947) stresses the importance of determining the strength of the opposing forces that contribute to resistance to change..

Olsen-Sitki et al. (2013) discuss a similar circumstance. The authors reported that within several months of the change to the bedside, report was occurring at the nurses' station, in the hallway, or in a conference room instead of at the patient's bedside as originally implemented. In the study, introduction of the oncoming nurse was consistently done, but there was little to no patient interaction. The nursing leadership team became acutely aware that the new process did not become part of the culture as intended (Olsen-Sitki et al., 2013).

Implementing change in health care can be challenging due to the complex nature of the environment (Anderson & Mangino, 2006); however, sustaining the change can be even more challenging**.** Lewin's change theory served as the framework for this project. A successful change includes "unfreezing" of the current behavior, moving to the desired behavior, and "refreezing" the changed behavior (Lewin, 1947). Kritsonis (2005) added that the change will not be sustained without refreezing. White and Dudley-Brown (2012) agreed that a "refreezing" of the new process must take place after implementation.

Implementation of bedside report on the telemetry unit occurred in late July 2014, however, sustaining the change in practice has been challenging. Nurses are observed giving report outside of the patient's room, in the workstations on the unit, and at times, at the main nursing station. Nurses frequently have to be reminded by the nursing manager to move report to the patient's bedside (S. Moore, personal communication, October 10, 2014). Giving report at the patient's bedside continues to be an uncomfortable practice for nurses on this unit.

In order for the telemetry unit's current practices to change, obstacles must be determined, specifically, barriers that keep nurses from performing shift report at the patient's bedside. Lewin's model describes driving forces that encourage the change and restraining forces that keep it from happening. The driving forces in the project included the benefits of bedside shift report supported by the literature, as well as the organizational goals of 100% participation in bedside shift report and patient- and family-centered care. The goal, therefore, was to create an environment where the driving forces are stronger than the restraining forces (Kritsonis, 2005; See Figure 2).

In order to change the behavior of the nurses, the restraining forces, or barriers to full implementation of bedside shift report for the telemetry nurses, must be identified. The restraining forces in Figure 2 are those identified in the literature, however, the specific barriers for this telemetry unit were not known. Assessment of the restraining forces for this particular telemetry unit was necessary in order to recognize how much of an influence the barriers contributed to impeding the accomplishment of bedside shift report (White & Dudley-Brown, 2012). This change model can be used to develop an

educational initiative to emphasize the driving forces and alleviate the restraining forces, once identified, in order to meet the desired state of full implementation of bedside shift report.

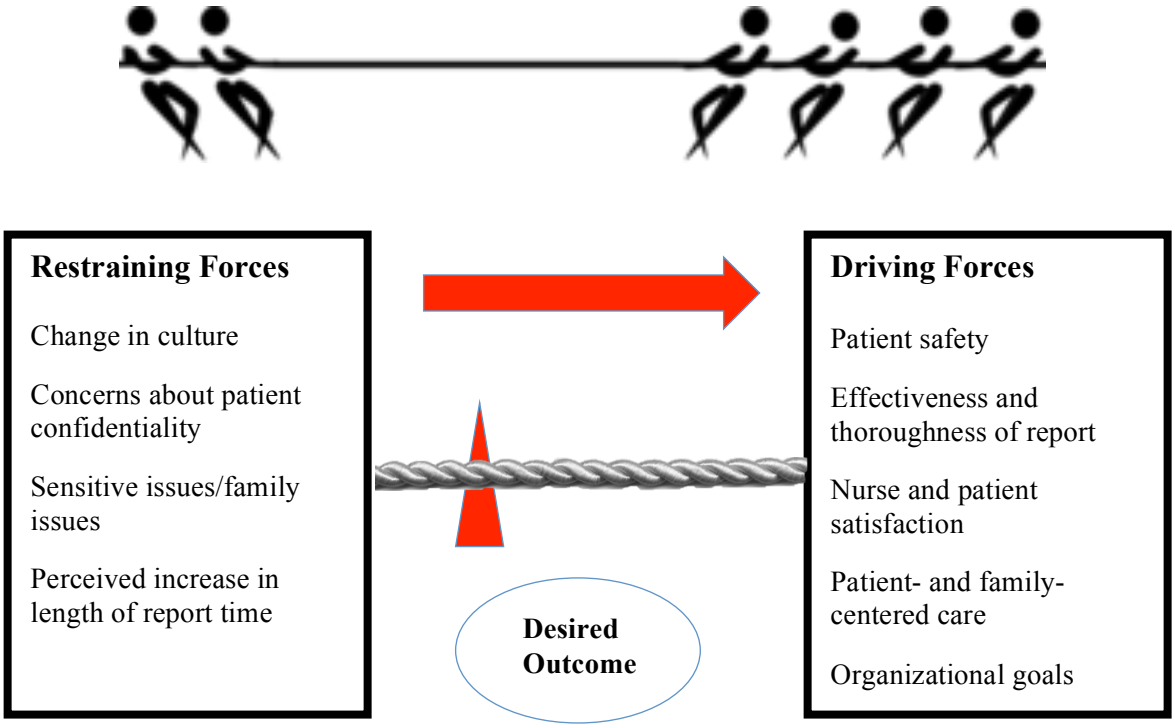

Figure 2. Lewin's model depicted as tug-of-war. The strength of the driving forces must overcome the restraining forces to reach the desired outcome (Lewin, 1947, p. 32). Restraining and driving forces adapted from; Anderson & Mangino, 2006; Alvarado, et al., 2006; Baker, 2010; Cairns et al., 2013; Caruso, 2007; Evans et al., 2012; Halm, 2013; Jeffs et al., 2013; Maxson et al., 2011; Radtke, 2013; Riesenberg et al., 2010; Sand-Jecklin & Sherman; Street et al., 2010;Tidwell, 2011; Vines et al., 2014; and Welsh et al., 2010). Image: Tug of War Long Clip Art. (2014). Retrieved April 9, 2015, from: http://www.clker.com/clipart-tug-of-war-long.html

Background and Context

The CNO established an organizational goal for all nursing units to participate in bedside shift report as part of patient- and family-centered care for a 250-bed Mid-Atlantic hospital as an automated system for change-of shift report was phased out (C. Cioffi, personal communication, October 6, 2014). Nurses who work on various units of

the organization were educated in the summer of 2014 about how to implement the change from recorded report to report at the patient's bedside. The unit manager and I observed nurses struggle to give report at the patient's bedside, as evidenced by the nurses outside the patient's room in the hallway or at the nurses' station (S. Moore, personal communication, October 10, 2014). This practice does not support the mission and philosophy of the organization, which centers on a culture of safety and patient- and family-centered care (Our Core Values, 2015). The organization strives to foster an environment of "communication and collaboration among all members of the patient/family/healthcare team" and to integrate evidence into every day practice (Our Core Value, para. 2).

The literature clearly identifies barriers to implementing and sustaining bedside shift report, and how those barriers impact performing report. It was not known what the nurses of the telemetry unit perceive as their barriers. The information collected during this project will be used to create an educational opportunity for the nurses of the telemetry unit to refine their current practice of shift report to one that supports the organization's goals. In addition, valuable information can be provided to other nursing units struggling with implementation and sustainability of bedside shift report.

I have worked in the organization for nearly 12 years, ten years in the staff education department and the last two years as a Clinical Specialist. I support the organization's goal to transform traditional shift report and move it to the bedside as a patient safety initiative and a reflection of the mission of patient- and family-centered care. Working in the patient care environment during change-of-shift report provided the

opportunity to witness challenges the nursing staff is experiencing with consistently performing report at the bedside since the practice was implemented in July of 2014. Barriers to performing report at the bedside must be identified and dealt with before the change can be sustained. This was accomplished through a focus group approach. Through this project, I listened to the concerns of the nurses not as a supervisor, but instead, as a colleague in the same working environment, and proposed an education plan to overcome barriers to performing change-of-shift report at the patient's bedside.

Summary

The literature search focused on the facilitators and barriers to bedside shift reporting. Patient safety, nurse and patient satisfaction, patient- and family-centered care, and goals of the organization serve as the facilitators for bedside shift report and are supported in the literature. Barriers described in the literature include concerns about patient confidentiality, sensitive issues with the patient and/or family, and the perceived increased amount of time to complete change-of-shift report. However, specific barriers to this group of telemetry unit nurses were not addressed. Lewin's change model will served as the theoretical framework for understanding how the facilitators (driving forces) and the barriers (restraining forces) impact the sustainability of bedside shift report on the telemetry unit. The information collected from this project will be used to refine the current practice of the telemetry unit nurses, and can provide important information to those units currently implementing bedside shift report or trying to sustain the practice change.

Section three describes the approach of the project to determine the barriers of telemetry nurses to fully implement bedside shift report as intended and provide education to overcome those barriers. The process, team, focus groups, review of evidence, development of the education plan and delivery will be discussed. In addition, plans for implementation and evaluation will be described.

Section 3: Methodology

Introduction

The purpose of this project was to identify the barriers that impede nurses from fully participating in bedside shift report using a focus group approach. Analysis of the information collected was used to create an educational initiative to refine the nursing staff's proficiency in performing bedside report. I led this evidence-based practice project and directed the activities involved in this process. In this section, I outline the core components of implementation and evaluation of the project. Refer to the Gantt chart time line (Figure 3).

1. A project team of stakeholders was assembled
2. Internal Review Board approval
3. Relevant evidence and literature was presented to the stakeholders
4. Four focus groups of five nurses each was assembled
5. An implementation plan for education delivery to nurses was developed
6. An evaluation plan to be implemented by the project facility was developed.

Timeline for DNP Project

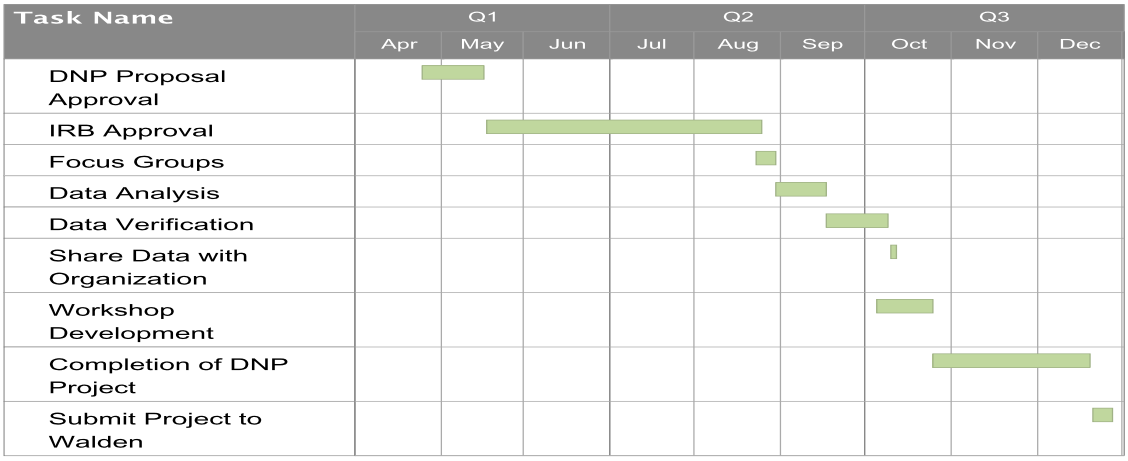

Figure 3. Gantt chart with project timeline.

Project Team

A team was formed to plan and implement this evidence-based practice project. Kelly (2011) emphasized that effective teams are not just formed, but also planned. Team members were invited to participate in this project because of expertise, ability, and interest with seeing this project advanced within the organization. Telemetry-registered nurses were invited to participate in focus groups to provide insight into why bedside shift report is not occurring as intended at the bedside. Crucial to success of this project was verification of the data analysis. Humans are subject to influences of training, backgrounds, and experiences. Inviting experts to verify the data analysis is a safeguard against this "selective perception" (Krueger & Casey, 2009, p. 115). Team members and their role in this project included the following:

1. I functioned as the focus group facilitator, transcriber, and data analyzer. Focus group approach detail can be found later in this section.

2. Full-time dayshift and nightshift telemetry nurses were invited to participate in focus groups on a voluntary basis.
3. The director of professional development and education (PhD), my preceptor, verified the data analysis due to her experience with nursing research and evidence-based practice projects.
4. The capstone project committee chair was not needed to verify the data analysis as there were no questions regarding the analysis verification. Review of the literature and data themes were shared with the CNO of the facility and the entire clinical leadership team (CLT) comprised of all of the clinical nurse specialists, clinical specialists, managers, and directors of the organization's nursing units).
5. The CLT team and I then brainstormed development of the educational intervention based on the data findings and the literature evidence.

Review of Evidence

It is important for the organization that nurses perform change-of shift report at the patient's bedside to align with their mission of patient- and family-centered care. A brief summary of the evidence and framework for the project was presented to the project team members. The project was implemented at a 225-bed community hospital in Maryland. The nurses participating in the focus groups were bedside nurses currently working 12-hour shifts on a telemetry unit within the hospital.

A summary of the evidence, including themes identified in the literature as barriers to sustaining bedside shift report, was presented to the clinical leadership team at

the onset of the project implementation. These themes were compared to those obtained through the focus group data analysis using the population of telemetry nurses at the project site. The comparison was highlighted in the presentation to the clinical leadership team at the project's conclusion.

Lewin's (1947) change theory served as the framework for the project. Resistance to change is often rooted in disruption of the situation or the inability to think beyond what is believed by those participating in the change (White & Dudley-Brown, 2012). Lewin's theory was used to assess the causes of resistance so that strategies can be developed by the project team to strengthen the forces moving toward the change and constrain the forces inhibiting change (Lewin, 1947). In addition, Lewin's theory was used to guide the evaluation of the educational intervention by observations of change-of-shift report at defined intervals. In addition, the model facilitated the integration of bedside shift report into the nurses' daily practice.

Focus Groups

Focus groups are a planned series of discussions designed to obtain perceptions of a topic through prepared open-ended questions (Krueger & Casey, 2009). The focus group interview approach gave me the opportunity to obtain the general attitude of the unit staff regarding their practice (Grove et al., 2013). Krueger and Casey (2009) identified five characteristics of focus groups, included below with a description from the proposed project:

1. People, (nurses) who

2. Possess certain characteristics (work on a telemetry unit at the project site and have been trained to perform bedside shift report as intended by the organization)
3. Provide qualitative data (perceived barriers to performing shift report at the bedside consistently)
4. In a focused discussion (facilitated by me)
5. To help understand the topic of interest (what keeps nurses from performing shift report at the bedside consistently)

A question guide was used to facilitate the discussion and to keep the focus group on task. Key questions asked during the focus groups are what drove the project (Krueger & Casey, 2009; See Appendix A for the focus group questions).

Recruitment and Sampling

Four focus groups were planned. Each focus group consisted of between four and six nurses who work full-time (36 hours per week) or part time (a minimum of 24 hours per week) on the telemetry unit. Each nurse participated in only one focus group. A similar number of dayshift and nightshift nurses were recruited. Participants determined which focus group they participated in based on availability. Participants were not provided the names of those attending the focus groups. Although the typical size of focus groups is five to 10 people, smaller groups can afford more opportunities for the nurses to share opinions (Krueger & Casey, 2009). The limited number also allows all participants to have the opportunity to respond to and discuss each of the questions asked (Terry, 2011).

A flyer was posted inside the unit break room, on the outside door of the break room, and at each nursing station on the telemetry unit requesting participation in the project (See Appendix B for the flyer). The flyer included two incentives: breakfast/lunch/dinner provided and the nurses had the opportunity to use participation in the focus group for points towards their clinical ladder (M. Gurzick, personal communication, April 1, 2015).

I discussed the project at morning huddles (brief gatherings of the staff to discuss important information) to encourage participation and clarify questions. The prospective participants were asked to call or e-mail me requesting to participate in one of the focus groups highlighted on the flyer. When contact was made, I determined if the prospective participant was full time or part time, and I asked what focus group they chose to participate in. It was stressed that participation was contingent on their off-shift availability. Prospective participants were asked for a phone number and e-mail address to be used for confirmation and reminder purposes only.

Ethical Considerations

The necessary paperwork was submitted in order to obtain approval from Walden University and the project site's institutional review boards (IRB) prior to the recruitment of the participants. During the confirmation call, the participants were informed that the sessions would be recorded for transcription purposes only. Notes were taken during the focus groups. Names were not used in any of the transcription or note taking. It was important that all participants were informed of the study's purpose, the study being voluntary and confidential, and that they can choose not to participate further at any time

(Krueger & Casey, 2009). In addition, when the participants arrived for the focus group discussion, they were given written material on the audiotaping of the session, personal confidentiality, and confidentiality regarding anything discussed within the session. They had the opportunity to ask questions and clarify information; the participants were then directed to sign an informed consent to verify their understanding of the information presented.

Each participant was assigned a code number. The list of names of the participants and their codes was kept under lock and key. After the focus groups, I transcribed all audio recordings and developed a transcript using only the assigned codes for the participants (Krueger & Casey).

Data Collection, Analysis, and Verification

This project followed the guidance for focus group interviews as outlined by Krueger and Casey (2009). Audiotape was used to capture the group discussion. Two taping devices were used, one serving as a backup. Immediately following the focus group, the audio recording was downloaded to my personal laptop computer and was saved in more than one location on the computer. I developed a transcript of the taped discussions. The transcript was checked against the audio tapings. An analysis of the transcript followed using a classic analysis strategy defined and outlined by Krueger and Casey, which allowed me to identify themes and categorize results. A descriptive summary was written for each category, capturing what was said in each of the groups. Themes were determined from these descriptive summaries (Krueger & Casey, 2009).

An analysis of the transcript is verifiable when another researcher arrives at similar findings using the same data (Krueger & Casey, 2009). My preceptor at the project site verified the findings. My preceptor was given a copy of the audiotape, a copy of the transcript, and the descriptive summaries. We then compared themes in order to verify the results that I obtained. The project first chair did not need to verify the findings as there was no uncertainty about any of the themes.

Develop Shift Report: Gaining Confidence at the Bedside Education

Curriculum Development

The thematic analysis was used to develop the curriculum for an educational workshop. In the analysis, I addressed barriers and concerns from the literature and those the nurses expressed in the focus groups. Key findings from this project, and those from evidence-based practice literature, were summarized in an oral presentation with visuals given to the CNO and clinical leadership team, including recommendations for curriculum content. The CNO and clinical leadership team provided feedback on the recommendations. I obtained approval of the proposed curriculum from the clinical leadership team.

Educational Delivery Modalities

Workshops are short educational programs designed to teach skills or techniques for participants who work in the same field; workshops include active participation and discussion and are limited to a specific period of time (KU Work Group, 2014). An interactive workshop was developed from themes in the literature and the unique barriers obtained from the focus groups. It will be offered to the telemetry nurses from the unit

where the focus groups are held. The themes will be shared with the participants followed by education covering skills that will help the nurses overcome the identified barriers. The nurses will have the opportunity to practice the skills learned through role-playing activities in a formal classroom setting. The workshop can be expanded to other units in the facility struggling to maintain bedside shift report.

Develop Implementation Plan

The implementation of the workshop will begin after communicating with the project team members, department CNS, the department manager, and nursing administration to determine the education hours that can be supported by the current budget or built into the budget for the next fiscal year. The following serves as the basic tentative plan for implementation of the workshop:

1. Determine number of education hours available for each nurse on the telemetry unit
2. Adapt workshop curriculum to be completed within the allotted time
3. Determine the number of times the workshop will need to be offered to accommodate each staff nurse
4. Determine dates and times of the workshop
5. Secure classrooms for the workshop
6. Work with the department CNS to ensure that all unit nurses are registered for the workshop
7. The project site will implement the workshop

Evaluation Plan

I will prepare the evaluation plan for the project facility to implement. The basic tentative evaluation will consist of two separate elements. The first part of the evaluation will be conducted on the unit where the focus groups were held. Baseline observational data of the frequency of shift report at the bedside using the communication boards and places other than the bedside will be obtained prior to the implementation of staff education. These baseline data will be measured for 5 days at each shift change by an independent anonymous observer using a checklist. The brief checklist will contain the following items:

1. Both nurses were at the patient's bedside for all, some, or none of the report.
2. If not at the bedside, where did the nurses give report?
3. If not at the bedside, ask the nurses "why not?"

After the educational workshop, observations will be conducted at 1 month using the same checklist. If barriers other than those covered in the initial education are identified, the team will address what additional education may be required. Education on those barriers will be provided, followed by independent anonymous observations conducted 1 month later. The second part of the evaluation will be for the educational workshop offered to the telemetry nurses. It will consist of a pretest and posttest developed from the literature and information presented in the workshop.

Summary

In this section, I addressed how the project was developed using evidence-based practice and a focus group approach in determining what telemetry nurses perceive as barriers to performing change-of-shift report at the bedside. Data collection and data analysis were outlined. Also presented was the development of an educational workshop and how that will be implemented based on the themes identified in the focus groups and in the literature. This section concluded with a two-pronged evaluation plan that will include both observational data of nurses performing change-of-shift report and a pre- and post-test approach to evaluate effectiveness of the educational program.

In Section 4, I summarize the findings and discussion of the project, implications/recommendations based on the findings, and the project's strengths and limitations. The section will close with a concluding statement about the project.

Section 4: Findings, Discussion, and Implications

Introduction

The National Patient Safety Goals include providing accurate information and the opportunity for the nurse to ask and respond to questions during shift report as part of effective handoff communication (TJC, 2007). TJC (2013) added that bedside shift report is an important practice to keep the patient and family informed about the plan of care for safe continuity of patient care. After a recent practice change from recorded to bedside report at this clinical site, telemetry nurses were observed not performing bedside shift report as intended by the organization. Nursing administration supports bedside shift report with nurse discretion regarding sensitive information that needs to be shared outside the patient's room and with special focus on the communication board (C. Cioffi, personal communication, October 28, 2015).

The purpose of this capstone project was to identify what telemetry nurses perceive as barriers to performing change-of-shift report at the patient's bedside. The goal of the capstone project was to develop a plan to educate and empower nursing staff to refine current practices in pursuance of improved communication skills for patient safety and quality patient care using bedside shift report. In the time period since bedside shift report was implemented by the organization, the change in practice was not occurring as intended (S. Moore, personal communication, October 10, 2014). Nurses were giving report outside the patient's room or in an alcove in front of a computer followed by rounding in the patient rooms (S. Moore, personal communication, October 10, 2014). Olsen-Sitki et al. (2013) discussed a similar circumstance after bedside shift

report was implemented. Olsen-Sitki et al. reported that within several months of the change to the bedside, report was occurring at the nurses' station, in the hallway, or in a conference room instead of at the patient's bedside as originally implemented. Understanding why the telemetry nurses in this project are noncompliant with change-of-shift report at the patient's bedside will provide the foundation for training sessions to better facilitate the practice change to bedside shift report.

As a part of this project, a focus group methodology was used to determine the barriers that keep the telemetry nurses from performing change-of-shift report at the patient's bedside. I found that while there are identified benefits to performing bedside shift report, the restraining factors, or barriers, are stronger than the driving forces that facilitate performing bedside shift report. The identified barriers obtained through the focus groups and evidence in the literature provided the foundation for the content of the proposed workshop.

Findings and Discussion

Focus Groups

The focus group implementation occurred under the supervision of the committee first chairperson. Four focus groups were held at an acute care facility with telemetry unit nurses as participants. The purpose of the focus groups was to gain an understanding of what telemetry nurses perceived as barriers to full implementation of bedside shift report as intended by the organization. Four smaller focus groups were planned and implemented so that participants had ample opportunity to respond to and discuss each of the questions asked. Prior to the start of each focus group, I explained the purpose,

benefits, and risks involved in the project. Participants had the opportunity to ask questions and clarify information. Each participant then signed a written consent. Full details on the transcript analysis process are addressed in a following section.

Each focus group identified benefits and barriers to the former telephonic recorded method of shift report and the recent change to bedside shift report. The participants highlighted the flexibility of the recorded report, stating that this type of shift report was comfortable, provided patient confidentiality, and allowed the user to tape report at a time that was convenient with limited interruptions. The nurse can add updates as needed, listen to report before the start of the shift, listen a second time if needed, and research patient information on the computer while listening to the report. However, nurses were unable to ask questions or clarify information, see the patient with the off-going nurse, and frequently encountered other nurses who did not use the technology properly. The recorded report was easy to unintentionally erase and time consuming to retrieve. In addition, focus group nurses indicated that the time spent recording could be spent directly with the oncoming nurse in one-on-one communication.

The focus group participants discussed several benefits of bedside shift report. These included being able to see the patient and perform safety checks, having direct communication with the oncoming nurse, asking questions and clarifying information, and physically showing the nurse wounds and other concerns. Several of the focus group nurses described feeling more confident and safe handing off the patient with both nurses in the room and often recalled additional information about the patient to relay while at the bedside. In addition, the focus group nurses stated that bedside shift report allows the

patients to be actively involved in the plan of care, see who will be caring for them, and the opportunity for the patient to ask questions. The focus group nurses further described bedside shift report as more interactive with the patients and with other nurses.

The focus group nurses identified several challenges with performing bedside shift report. Each focus group emphasized frequent interruptions as a barrier to bedside report, especially calls to receive report on a patient admission or transfer, receive an admission or transfer, and attend to patient needs during the report process. One example frequently mentioned was having to toilet the patient in the middle of giving report. Aides, nurses, and charge nurses are busy giving and receiving report; therefore, they unavailable to answer call lights in a timely manner. Other barriers highlighted by the focus groups include a lack of consistency in what is given in report, confused patients, and waking patients in the morning to give report at the bedside.

Focus Group Demographics

There were a total of 18 participants in the focus groups. All of the nurses who participated in the focus groups were female, ages ranging from 25 to 59. Both dayshift and nightshift were represented, and years of experience ranged from less than 1 year to 37 years. There were four to six participants in each of the focus groups (Table 1).

Table 1

Combined Demographics of Focus Groups

Item	**N (%)**
Total number of participants	18 (100)
Gender	
Female	18 (100)
Age	
20-30	6 (33)
31-40	2 (11)
40-50	4 (22)
50-60	6 (33)
Position	
Clin I	2 (11)
Clin II	9 (50)
Clin III	7 (39)
Shift	
Days	10 (56)
Nights	8 (44)
Status	
Full time	15 (83)
Part time	3 (17)
Experience	
Years as RN	
< 1–3	7 (39)
4-10	5 (28)
11-20	4 (22)
> 21	2 (11)
Years in current hospital	
< 1-3	10 (56)
4-10	5 (28)
11-20	2 (11)
> 21	1 (5)

Transcript Analysis Process

The questions that I asked during each focus group can be found in Appendix A. Responses to the questions and focus group interactions were recorded by me on to a digital device and were immediately downloaded to my personal computer after each

focus group session. I transcribed the recorded focus groups proceedings and compared them against the audio tapings. I listened to the tapings while simultaneously reviewing the transcript. A classic analysis strategy defined and outlined by Krueger and Casey (2009) was used to analyze the transcript. The transcripts were printed and then cut into individual quotes. The quotes were categorized according to each question asked in the focus groups. All of the quotes that communicated similar ideas were placed together under the appropriate question. A descriptive summary was written for each of the questions, and themes were identified. A copy of the full transcript and identified themes were shared with my preceptor who concurred with the findings.

Thematic Analysis

Themes in Focus Groups Supported by the Literature

Ineffective patient handoffs are recognized consistently in the literature as a patient safety issue (Street et al., 2011) regardless of the method of report used. Bedside shift report is no exception. Some themes from the focus groups were similar to those identified in the literature. The most frequently mentioned barrier in each of the focus groups was constant interruptions resulting in an incomplete or ineffective report. Nurses identified numerous phone calls, patient call lights, too many questions from the other nurse or the patient, and attending to patient needs during report as major restraining forces (Table 2).

Focus group nurses expressed the same types of fears and apprehensions as reported in the literature with not knowing what can and cannot be discussed at the bedside, but were more concerned about bringing up issues that have not yet been

discussed by the physician, such as test results and new diagnoses (Anderson & Mangino, 2006; Cairns et al., 2013; Evans et al., 2012; Radtke, 2013; Sand-Jecklin & Sherman, 2013). Focus group nurses expressed concern and unease with patient confidentiality and Health Insurance Portability and Accountability Act (HIPAA) violations and other sensitive issues being discussed at bedside (Table 2).

The lack of consistency of what information was presented at the bedside is another example of the focus group nurses' perception of incomplete report that is supported in the literature. This variability in report content increases the risk for missed or incorrect patient information, thereby jeopardizing patient safety (Alvarado et al., 2006). Street et al. (2011) reported similar findings of variability in the information exchanged during bedside shift report. The focus group nurses revealed that this variability results in missed information.

According to the focus group nurses, further information loss occurs when telemetry nurses rush to complete report in order to give report to one or two other nurses. Finally, the nurses described "censoring" information at the bedside, only talking about the "lighter stuff," all potentially resulting in compromised transfer of information from nurse to nurse (Table 2).

Table 2

Themes in the Literature with Quotes from Focus Group Participants

Themes	**Quotes**
Confidentiality and sensitivity	"There are instances where you want to say something that may not be appropriate for the patient to hear, but the nurse needs to know, like behavior issues or family situations."
	"I sometimes worry about privacy. I would be uncomfortable saying some things in front of the patient or family."
	"It's uncomfortable because the doctors don't always communicate with the families, and we have families that don't want the patients to know the information."
Incomplete or ineffective report	"All the interruptions break up the flow of communication; then you forget where you are (in report) and what you are saying." "Everyone does their own thing so you never know what you will be getting."
	"The nurses go off on tangents"
	"There needs to be some standard way of doing it. When I'm not getting important information; it is a problem."
Lengthy report	"I haven't gotten my shift report and it's 8am because of the length of report."
	"It's also a time factor because of all the interruptions, and there are a lot of interruptions – call bells because everyone is in report and no one to answer them, phone calls, and questions from nurses and patients."
	"You go into the room and the patient always wants something and now it takes 15 minutes to take the patient to the bathroom.

Researchers reported an overall decrease in the length of time it takes to give change-of-shift report at the bedside versus traditional methods of giving report, even though the scholars indicate that time commitment is a concern expressed by nurses as a barrier (Anderson & Mangino, 2006; Cairns, 2013; Caruso, 2007; Tidwell, 2011). Nurses from the focus groups expressed concerns about the amount of time invested in

giving report. Interruptions, nurses and patients asking too many questions, and attending to patient needs during report all contribute to the perceived increase in length of report at the bedside. Longer reports lead to late starts and an overall feeling of being behind from the start of the shift (Table 2).

Themes in Focus Groups Not Supported by the Literature

Focus group participants revealed barriers that were not evident in the reviewed literature. Focus group nurses reported not only all the above listed interruptions, but more concerning to them is being required to take report on and accept admissions and transfers during bedside shift report time. Nurses perceived the times from 7:00 to 7:30, both morning and evening, as critical times to get essential information in order to provide safe patient care. This theme was echoed throughout all of the focus groups. The focus group nurses perceived this as a significant patient safety issue, and verbalized a strong desire for a dedicated report time. The "unprotected time period" theme generated emotional discussion and responses; however, it could not be substantiated in the reviewed literature. This theme may be unique to the organization (Table 3).

Focus group nurses described frustrations with call lights not being answered because nurses, charge nurses, and aides were all receiving report at the same time. The nurses expressed concern regarding patient safety and reported an increased possibility of patient falls and rapid response calls being made as staff are not readily available to answer call lights in a timely manner. Focus group participants suggested that staggered report times would alleviate some of the frustration and concern associated with call lights not being answered during report time (Table 3).

The final theme incited additional emotion. The nurses expressed frustration when discussing waking the patients for the morning shift report. Patients are wakened frequently between 4 am and 7 am for vital signs, labs, EKGs, and echocardiograms. Nurses cite that the first thing many patients complain about in the morning is the hourly sleep disruptions (Table 3).

In addition, confused patients provide another source of frustration with bedside shift report. According to the focus group nurses, patients that are confused do not understand what is being discussed at the bedside, which frequently results in patient agitation. None of the studies reviewed reported these three findings as barriers to bedside shift report (Table 3).

Table 3

Themes not in the Literature with Quotes from Focus Group Participants

Unprotected time period for report	"Critical labs being called is ok, but three patients rolling up during that time, things get missed when interrupted. You can only get interrupted so many times before you start to lose information or get so bombarded that you lose the details."
	"Errors are communication errors. There should be some kind of protection for that time period."
	"We are not allowed to tell the ED we can't take report that we'll call them back. We're not allowed to do that. We have to stop what we're doing, whatever we're doing and take that physical report over the phone."
	"If this is important to them, then we need that protected time. We can't do it on our own."
Patient satisfaction	"If it's supposed to contribute to patient satisfaction, there is no satisfaction with the patient being woken up 4 times between 4 and 7am."
	"Patients are still trying to sleep and they don't want to be bothered and are not involved at all."
	"You feel like you're just bothering them. It seems like a waste of time because they are all sleeping. It is even appropriate to wake them?"
	"They (confused patients) don't understand what we are saying which sometimes causes them to get stirred up."

Communication Board

Earlier this year, updated communication boards were placed in each of the patients' rooms. The nurses in the focus groups described the current use of the boards and a desire to use the boards more effectively by incorporating them into bedside shift report. The communication board is pertinent to this capstone project as the nurses in each of the focus groups discussed this topic.

The communication boards are whiteboards implemented to keep the patient and family updated on important patient information and facilitate communication between the staff, the patient and family. The Patient- and Family-Centered Advisory Council, whose membership includes individuals from the community, designed the boards; therefore, the community gave input about what they would like communicated to them during hospitalization. The shift caregivers, family contact information, plan of care for the day, goals, anticipated tests or procedures, and the discharge plan are all components of the communication board (D. Sullivan, personal communication, May 11, 2015; See Appendix C).

Communication whiteboards are commonly used in acute care facilities (Johnston, 2014). Wakefield, Ragan, Brandt, and Tregnago (2012) included updating communication boards in the patients' rooms as the third step in a redesigned bedside shift report process that facilitated two-way communication between the nurse and patient/patient's family. Wakefield et al. added that use of the whiteboards was one component in standardizing bedside shift report. In addition, Singh et al.(2012) reported that patient satisfaction scores significantly improved after whiteboards were placed in patient rooms on a general medical unit. In addition, referring to the confidentiality of whiteboards, "the HIPAA Privacy Rule is not intended to impede these customary and essential communications and practices" (HHS.gov, 2003). In accordance with Privacy Rule, the organization "has in place reasonable safeguards" to protect patient information (HHS.gov, 2003). These safeguards include location of the patient communication whiteboards in patient rooms; whiteboards do not display patient names, and do not

contain sensitive patient information. The organization does not currently have a policy for the communication boards; however, content of the whiteboards should be included in the proposed policy on bedside shift report.

Recommendations for Policy and Practice

Bedside shift report requires clear guidelines for practice and policies that communicate specific standards supported by the organization (Clarke & Persaud, 2011). Currently, the study site organization does not have a policy or procedure to guide the practice of the telemetry nurses when performing bedside shift report. The policy must include required communication tools, such as the communication board and written report template, and specific guidelines on how these tools will be utilized to facilitate communication at the change-of-shift. An organizational policy should provide clear expectations of what information should be conveyed by the nurses at the bedside and what information is acceptable to communicate away from the bedside. Even though bedside shift report was an expectation communicated to the nurses, the process must be reflected in an organizational policy.

The reviewed literature supports the use of bedside shift report; however, nursing leadership should be cognizant of the focus group concerns and develop a plan to address those concerns. Sand-Jecklin and Sherman (2013) concluded that leadership must speak to inconsistencies and perceived barriers to the practice change and implement interventions to remove those barriers. It is important to understand current bedside shift report practices, and the barriers and facilitators, in order to develop an effective

intervention plan (Wakefield et al., 2012). The barriers identified by the focus group and in the literature should inform policy development.

The nursing staff will require education on this practice change and the proposed organizational policy would serve as one framework for the education sessions. Policy content needs to drive the education. Nurses must clearly understand all expectations to which they will be held accountable.

Implications

Although change-of-shift report takes place on a daily basis, there continues to be problems associated with lack of consistency and communication of essential patient information in a timely manner using bedside shift report. The goal of this project was to develop a plan to educate and empower staff nurses to refine bedside shift report, in pursuance of improved communication skills for patient safety and quality nursing care using the information obtained through the focus groups. On the basis of the findings of the focus groups, several recommendations were made to nursing leadership including leadership communicating the organization's goal of bedside shift report, developing a prepopulated report sheet, staggering nursing staff start times, and consideration of a dedicated report time.

Nurses may be unaware of the inherent risks involved with shift report and best practices in the literature to lessen those risks (Clarke & Persaud, 2011). Heightened awareness can be achieved through leadership communicating how the best practice of bedside shift report supports the organizational goals of patient safety and patient- and

family-centered care. Staff nurses must understand the organization's goal for bedside shift report and the outcomes to be achieved.

A computer is located in each patient room allowing the nurses to access lab results and other pertinent information to communicate to the on-coming nurse during bedside shift report. However, accessing this information in the patient's room may be perceived by the nurse and the patient as detracting to the nurse/patient interaction at the bedside. Developing a prepopulated computer generated shift report tool incorporating this information may alleviate these misperceptions and provide a standardized method of communication at the bedside.

Nurses revealed that one significant interruption during report was not having staff available to answer call lights while the nurses were in the midst of giving and receiving report. Staggering the start times for the charge nurses, staff nurses, and nursing assistants would address the perceived patient safety issue created by staff not being available to answer call lights during change-of-shift. Focus group nurses suggested altering the start times would provide for available staff to answer call lights and attend to patient needs without compromising nursing communication. In addition, Spanke and Thomas (2010) reported nursing assistant walking report and rounds at shift change may have decreased the number of times the call lights were used by the patients. In this study, visibility of the nursing assistants rounding and performing safety checks may have been the explanation for an actual reduction in the number of call lights during shift report and an increase in patient satisfaction data. At this time, nursing assistants receive face-to-face report in the nurses' stations. Changing the practice of nursing

assistant report may alleviate the frequent call light interruptions for the nurses during bedside shift report (Spanke & Thomas, 2010).

Finally, it was recommended that nursing leadership consider a dedicated report time. Nurses passionately discussed the impact that being required to accept report, admissions, and transfers during change-of-shift has on the quality and effectiveness of report, and the safety of patients both on the unit and those coming from other areas of the hospital. Although a policy does not exist, it is understood that nurses must receive report, admissions, and transfers from the emergency department and other units at any time, including change-of-shift. Focus group nurses assert that dedicating a time for bedside report may significantly decrease the number of interruptions faced by nurses allowing for a more effective and efficient communication. However, there may be a gap in nurses' understanding the overall implications of a dedicated report time system-wide. For example, the emergency department has specific metrics to meet regarding length of time a patient spends in the ED prior to admission. The knowledge gap can be addressed during the planned educational workshop.

It is important to discuss inconsistencies and barriers in shift report. It is also important to provide nurses with effective communication skills for dealing with questions and interruptions while trying to participate in an efficient change-of-shift report. Utilizing case studies and role-playing during education sessions will give the nurses examples of scripts that can be used in response to patient and family questions, to facilitate bedside shift report using the communication board, and, may address concerns with confidentiality and sensitive issues (Cairns et al., 2013). Almost two thirds of

sentinel events in acute care centers can be attributed to miscommunication of patient information at shift change (Cornell, Townsend-Gervis, Yates, & Vardaman, 2013). It is critical that nurses understand the positive impact that consistent, timely, and effective shift reports have on providing safe, quality patient care.

Strengths and Limitations

Strengths of the project were the diverse levels of nursing experience, number of years at the current organization, and skill level of the nurses participating in the focus groups. Another strength was that nurses identified several themes that were consistent with the literature regarding barriers to bedside shift report. In addition, this project uncovered new themes that can be explored further.

Several limitations were identified in this project. The project took place using volunteer nurses from only one unit in a single organization, therefore, limiting the generalizability of the findings. Second, the nurses were providing opinions about what they perceived as barriers to bedside report, which caused some concern about the validity of responses. Third, opinions could be swayed by what was being discussed within the focus groups. Fourth, I am a colleague of the nurses and responses may have been skewed based on what they thought I wanted to hear. Finally, I conducted the focus groups with limited experience leading this type of discussion.

It was assumed that all nurses received education prior to the implementation of bedside shift report. However, the nurses emphasized the need for further education on the purpose of bedside shift report, the type of bedside report once determined by leadership, and communication skills to deal with patients and other nurses. In addition,

the nurses recognized the lack of education for the patient regarding bedside shift report. It is recommended to include these points in the education plan.

Recommendations for future projects include:

1. Nurse-led work group to determine essential information to pre-populate the computer generated report sheet.
2. Project team to determine the impact of a dedicated report time on admissions and transfers.
3. Study to determine the impact of staggered shift start times for nursing staff on the timeliness of answering call bells at change of shift.

Analysis of Self

I demonstrated growth in several areas regarding this project. In health care, as with many aspects of life, there is always room for improvement. Recognizing that bedside shift report was not occurring as intended by the organization was just the beginning of this student's journey. Addressing this issue required discovering the best practices currently available in the literature, interpreting the results, and evaluating the implications for nursing practice, in this case, bedside shift report.

Scholarship is not only the generation of new knowledge, but includes sharing that knowledge "through scientific and social exchange" (Zaccagnini & White, 2011, p. 64). Disseminating results is an important feature of scholarship, therefore, findings of the focus groups were presented to the clinical leadership team. As a result, the CNO requested to have the results of this project presented at the patient- and family-centered care committee meeting, the patient and family advisory council, and the patient

satisfaction and patient education committee. As a scholar and practitioner, I learned how to design, plan, implement, and lead focus group discussions. Performing this project allowed for implementation of a classic analysis strategy to systematically categorize the focus group data into specific themes and interpret the results. Although challenging, I increased my level of confidence in the elements of scholarship.

According to Zaccagnini and White (2011), one of the key functions of the DNP role is to educate staff. In order to develop the education plan, it was important me to understand the beliefs and attitudes the nurses have about the current push to bedside shift report, and orient the sessions to the barriers determined by the nurses and those in the literature. Growth as a scholar and practitioner is demonstrated through incorporating theory and evidence in the literature into the evidence-based practice project and the education plan proposed to the organization.

Managing this project was challenging. Multiple revisions of the Gantt chart were required due to inaccurate planning of the unanticipated number of reviews, corrections, and resubmissions of the proposal. Insufficient time was allotted for review at each stage of the process. I am now keenly aware of the time commitment involved and the flexibility needed when planning an evidence-based practice project. Program management is certainly the area where the most growth was achieved, and the area that requires continued attention. However, I gained an overall improved confidence level for implementing future evidence-based practice projects.

My long-term goal is to continue to grow as a scholar, practitioner, and program manager by implementing evidence-based practice projects to improve patient care,

quality, and safety, and to involve the bedside nurses in these projects. This goal can be accomplished by implementing the education plan for the nurses at the practicum site with full support of the clinical leadership team. A second goal is to not only share the results of the capstone project, but to share the impact of the education sessions on the current practice of bedside shift report on the telemetry unit.

Development and implementation of this project has provided me the opportunity to gain experience in the roles of scholar, practitioner, and project manager for future evidence-based practice projects. In addition, the project has significantly contributed to my professional development through gained skills to function as a change agent in the organization by working with nurses and nursing leadership to bring evidence-based practice to the bedside.

Summary

Errors in communication at change-of-shift report are responsible for two-thirds of sentinel events in hospitals today (Cornell, Townsend-Gervis, Yates, & Vardaman, 2013). Although the literature describes barriers to bedside shift report, it was not known if telemetry nurses perceived those same barriers that keep them from performing change-of shift report at the patient's bedside at this institution. A focus group approach was taken to understand the barriers from the telemetry nurses perspective in order to individualize education to this particular institution based on evidence and findings among the nurses themselves.

An organizational policy is needed to clearly define the meaning and goals of bedside shift report and clearly delineate the specific expectations of the nursing staff,

including the use of the communication board. Nursing assistants should perform report during walking rounds at change of shift to ensure call lights are answered in a timely manner for patient safety. An education plan was developed to assist the nurses in obtaining the necessary skills to report at the bedside using the communication board for consistency among all staff and to comply with regulatory requirements.

Section 5 presents the scholarly product based on the results of the evidence-based practice project. A plan is presented to the clinical leadership team on how to implement and evaluate an educational intervention to improve nursing communication skills and improve bedside shift report for the nurses on the telemetry unit. I then share dissemination plans including a poster presentation and publication.

Section 5: Scholarly Product

Introduction

The scholarly product for this project is the development of curriculum content for an education workshop to improve the necessary communication skills for nurses on a telemetry unit to deal with patient and nursing questions, confidentiality and sensitivity issues, and giving report at the bedside using the communication board for consistency among all staff. I will discuss recommendations for the implementation and evaluation process for this workshop. Dissemination of the project at the organization will be discussed.

Workshop Curriculum

The content for the curriculum was developed from the thematic analysis of the focus groups from the project and the literature. Lewin's change theory was used as a framework in guiding the set-up of the workshop curriculum and activities. Methods for presenting the workshop includes didactics, class discussion, case scenarios, and role-playing. Although mentioned in nursing orientation, there is no formal training that newly hired nurses receive on bedside shift report or the communication boards. Street et al. (2011) discussed that training in communication can impact teamwork and the overall goals of patient satisfaction and safety.

Lewin's Change Theory

Lewin's change theory served as the framework for this project. A successful change first requires "unfreezing" the current behavior (Lewin, 1947). In this case, it is necessary to address what the nurses identified as barriers to bedside shift report.

Moving to the desired behavior, Lewin's second stage, and another component of successful change, describes the workshop (Lewin, 1947). The workshop gives me the opportunity to educate nurses through interactive sessions that will allow nurses to revise and improve shift report through effective communication (Table 4). The final phase of Lewin's change theory is "refreezing" the new behavior, and it must take place in order for a change in practice to be sustained (Kristonis, 2005). Refreezing will be accomplished through practicing the learned skills in the workshop, giving the nurses timely feedback, and ongoing evaluation of the education provided (Table 4).

Table 4

Curriculum as it Relates to Lewin's Change Theory

Stage of Lewin's Theory	**Curriculum content**
Unfreezing	Explanation and rationale for bedside shift report
Moving	Communication skills and role-playing
Refreezing	Practice and provide feedback; ongoing evaluation

Curriculum Content

As revealed in the focus group themes, nurses can become stressed and frustrated when the information they are seeking is not available, not communicated effectively, or is not communicated effectively (Street et al., 2011). It is therefore recommended that "Principles of Communication" lead the workshop. The content within this topic includes: communication defined, non-verbal communication, active listening, relationships in communication, and decoding the message (Kourkouta & Papathanasiou, 2014).

Objectives for the workshop include:

- Participants will be able to describe the four elements of communication discussed in the workshop.
- Participants will participate in discussions related to barriers to bedside shift report that were identified in the focus groups and in the literature.
- Participants will participate in creating a scenario of a barrier to bedside shift report previously experienced.
- Participants will be able to compare and contrast the elements of communication and use them in developing case scenarios to role-play appropriate communication skills during change-of-shift report.
- Participants will provide feedback to other groups in the workshop using the elements of communication.

In order to make a change in practice, attitudes and beliefs towards bedside shift report need to be identified and challenged by the nursing staff (Vines et al., 2014). The next section of the workshop will include content that addresses the themes discovered in the focus groups. Utilizing the themes for case studies adds an "element of reality and relevance to the experience" (Cairns et al., 2013, p. 164). The strategy will be to divide nurses into groups and brainstorm specific situations encountered during bedside shift report in line with the identified themes that keep them from performing change of shift report at the bedside. The situations from each group will be shared with the rest of the workshop and written for the class to see (Table 5).

The next section of the workshop will consist of taking those case scenarios identified by the participants and role-playing the same situations, however, new

communication strategies will replace existing attitudes and behaviors. The presenters will demonstrate communication strategies, and then the individual groups take their case scenario and incorporate improved communication skills. Role-playing provides the opportunity to directly improve communication skills while gaining confidence in performing bedside report (Cairns et al., 2013; and Caruso, 2007). In one study, role-playing using case scenarios gave the participants the opportunity to use "credible scripting options" in response to questions from nurses and patients, and deal with concerning situations such as confidentiality issues (Cairns et al., p. 164).

Table 5

Curriculum for Workshop on Bedside Shift Report

Topic	**Content**	**Method**	**Time**
Communication skills	Communication defined hours Non-verbal communication Active listening Relationships in communication Decoding the message	Didactic	1.5
Case scenarios	Confidentiality and sensitivity Incomplete or ineffective report Lengthy report Unprotected time for report Patient satisfaction	Class discussion	1 hour
Role-playing case scenarios	Group role-playing of case scenarios	Role-playing	1 hour
Rehearsing the objective	Each group role-plays scenarios with the	Role-playing and feedback	1 hour

groups giving feedback
and suggestions.

According to Hohenhaus, Powell, and Hohenhaus (2006), role-playing allows for practice of both giving and receiving information, which is an important component of improving patient safety. Each of the groups develops a role-playing scenario that incorporates improved communication skills and present to the workshop. Other groups in the workshop provide feedback on the presentation. After all of the groups have presented, a second scenario is role-played followed by group feedback.

Implementation

Recommendations for the implementation of the workshop were presented to the project team, followed by the clinical leadership team. Approval of the content was obtained from the clinical leadership team. Recommendations from the teams were incorporated into the finalized workshop content. The organization will be responsible for the implementation of the proposed workshop. The clinical leadership team, in conjunction with the Clinical Education Center (CEC), will provide the instruction for the didactic portion of the workshop. The clinical nurse specialist group (CNS) will provide guidance and feedback for the class discussion, role-playing, and practice portions of the curriculum once approval of the content has been obtained. The CNO will determine the number of classroom hours that can be supported by the current fiscal budget. The number of workshop hours may need to be adjusted based on the number of dollars available.

The clinical leadership team will determine the number of times the workshop will be presented to accommodate schedules and staff availability. The dates and times of the workshop will be determined by the availability of the clinical leadership team and CNS groups. The CEC will secure classrooms for the workshops. The CNS group will ensure all unit nurses are registered to attend the workshop.

Evaluation

Based on the recommendations made by the DNP student to the clinical leadership team, the organization can expect to see an improved shift report with improved nursing communication skills. A pretest posttest method of evaluation can provide the organization with an assessment of knowledge gained during the proposed workshop. To ensure effectiveness of the change, the organization should institute competency validation as part of the unit orientation process.

Nursing Orientation

Focus group results indicated a lack of staff education related to shift report. The organization should develop a comprehensive bedside shift report policy and then incorporate the proposed policy into nursing orientation, first in the classroom and reinforced with orientation on the unit. Communicating shift report information in orientation provides the opportunity for the organization to emphasize expectations from the start. The organization's orientation "is to assure that all employees are competent to perform the duties and responsibilities of their job as outlined in the job description and are consistent with policies and practices relating to patient safety" (Competency Assessment Program, 2013, p. 1).

Dissemination

A presentation was developed and disseminated to the clinical leadership team including content of the workshop (See Appendix E). The clinical leadership team will discuss how the project can be monitored long term. I will work with the preceptor to implement the project at the organization. In addition, I am submitting an abstract for consideration for a poster presentation at the National Association of Clinical Nurse Specialists Summit and Education Forum in March, 2016 and publication in *Clinical Nurse Specialist.*

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Appendix A: Focus Group Questions

1. Recently, VoiceCare was eliminated from the organization as a method of shift report. What features of VoiceCare allowed you to have a better shift report?
2. What barriers to an effective shift report did VoiceCare present?
3. What enhances communication at change-of-shift with bedside report?
4. What are the barriers to this type of shift report?
5. What would improve your proficiency at giving shift report at the patient's bedside?

Appendix B: Flyer for Recruitment

I Need You!

I'm looking for telemetry nurses to participate in an **evidence-based project** on shift report. I want to gather nurses' opinions in a focus group setting about change of shift report. But I can't do it without you!

What do you have to do?

Just participate in **one** 45-minute focus group. You choose:

Mon., August 17, 1730 in Classroom 3

Wed., August 19, 0730 in Classroom 2

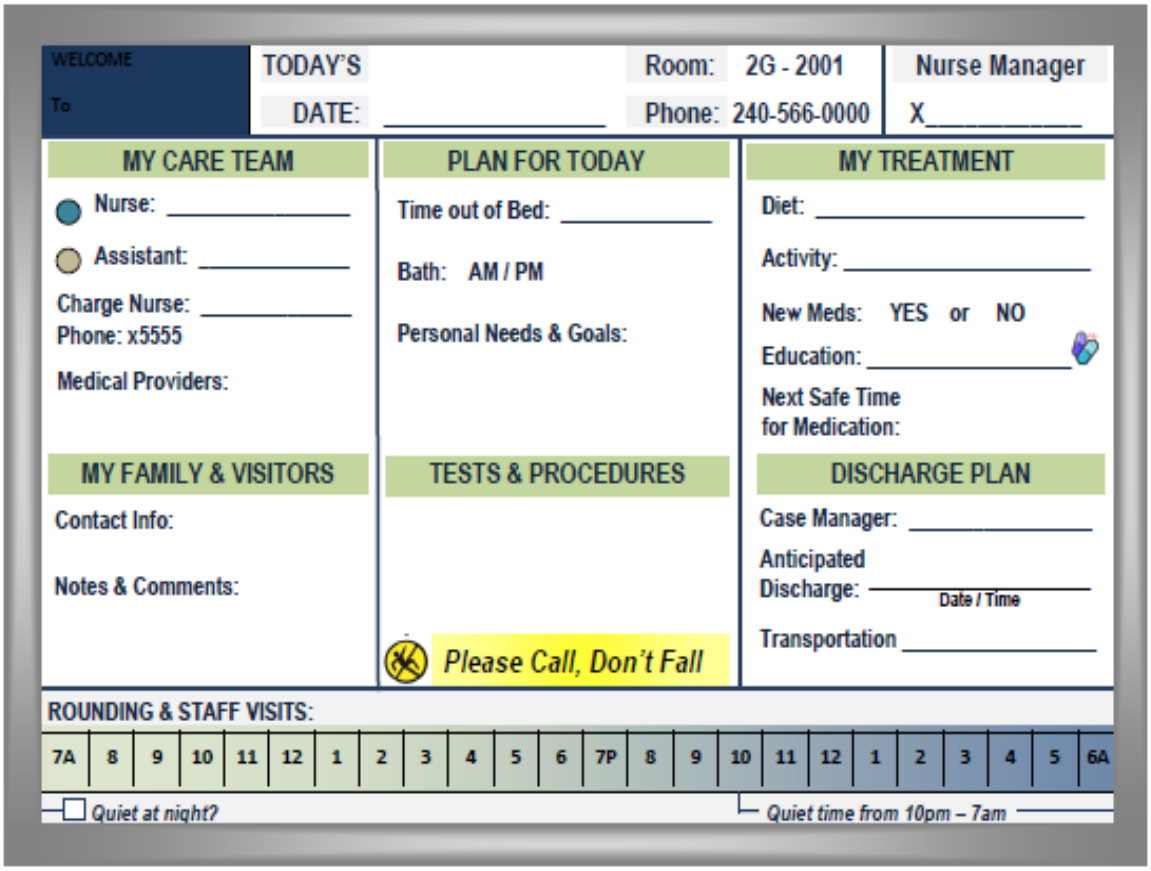
Wed., August 19, 1530 in Classroom 1

Thurs., August 20, 0730, 2G conference room

Food provided! You can use this for points on your clinical ladder!

Contact Beth Cipra at x4218 or ecipra@fmh.org to **be part of this important focus group on change of shift report**.

Appendix C: Communication Board



Appendix D: Presentation to Clinical Leadership Team

The move from recorded to bedside shift report: evaluating barriers to full implementation

Beth Cipra, MSN, CNS, CCRN-K

Background

- Problems associated with change-of-shift report
  - Lack of consistency and structure
  - Potential failures in communication
  - No opportunity for patient to be involved in plan of care
- Ineffective communication contributes to:
  - Adverse and sentinel events
  - Errors
  - Care omissions
  - Delayed, inappropriate, or repeated treatments
  - Increased lengths of stay
  - Avoidable readmissions
  - Increased costs

(Cairns, Dudjak, Hoffmann, & Lorenz, 2013; Halm, 2013; Jeffs et al., 2013; Riesenberg, Leitzsch, & Cunningham, 2010)

Background (Continued)

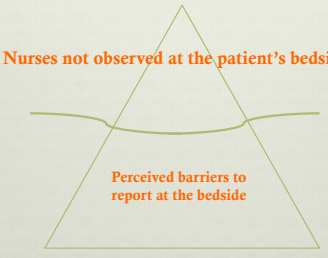
- Support of bedside shift report
  - Effective communication
  - Better health outcomes
  - Patient-focused care
  - Application of evidence-based practice
  - Patient involvement in handover process
  - Perform safety and quality checks
  - Ask questions and clarify information
  - Check for misinformation
  - Visualizing patient

(Jeffs et al., 2013; Radtke, 2013; Petersen, Blackmer, McNeal, & Hill, 2013)

Problem

- Organizational goal to move shift report to bedside
- Evidence supports bedside shift report
  - Patient safety
  - Quality outcomes
- Observations on a telemetry unit at change-of-shift revealed nurses were not consistently at the bedside
- Unknown what telemetry nurses perceive as barriers to moving shift report to the bedside

Purpose

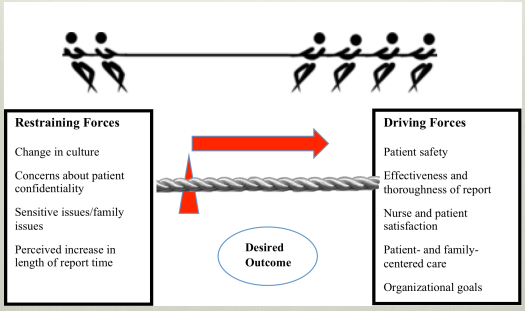


(Adapted from Kelly, 2011, p. 35)

Project significance

- Compliance with The Joint Commission
  - Ability to ask and answer questions
  - Informed patients and families
- Meet organization's goal of patient- and family-centered care
- Identification of barriers will:
  - Inform staff and leadership
  - Serve as a guide for change management strategies and education sessions
  - Inform other units

Theoretical Framework



Project approach

- Focus Groups
  - Carefully planned discussions
  - Specific topic
  - Opportunity to understand general attitudes of staff regarding bedside shift report

Krueger & Casey, 2009; Grove, Burns, & Gray, 2013; Terry, 2011)

Data collection and analysis

- Audiotape of focus groups
- Transcript
- Classic Analysis Strategy
  - Verify themes
  - Categorize results
    - Descriptive summary of each category
- Verification of results by preceptor

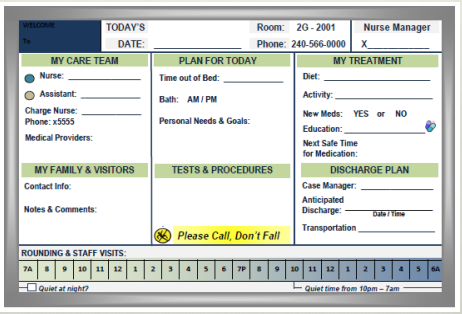
Focus group themes and descriptions of barriers to performing bedside shift report

Themes	Descriptions
Confidentiality and Sensitivity	Not knowing what can and cannot be said at the bedside Afraid of bringing up something the physician has not told the patient and/or family Certain things that the nurse needs to know but shouldn't be said in front of the patient (i.e., psych consult, behaviors, diapers, CIWA, etc.)
Incomplete or Ineffective report	Constant interruptions (breaks up flow of communication and may inadvertently omit important information): -Phone calls, call bells (everyone is getting report so there is no staff available to answer call bells) -Nurses/patients asking questions throughout report instead of listening first then asking -Patient needs: toileting, coffee, pain meds, etc. Lack of consistency in report resulting in too much or not enough information Rushing to give report to 1 or 2 other nurses Censoring information given at the bedside resulting in compromised transfer of information to nurse; not the same as if given in private

Themes	Descriptions
Lengthy report	Interruptions Patients/nurses asking too many questions Waiting around to get report; often have 2-3 nurses to get report from, often not receiving report until 0800 Results in being late with morning medications and treatments – could be 1000 or 1100 before all patients are seen Attending to patient needs during report

Unprotected time for report	Must take report on new admissions and transfers during report time (charge nurses in report at the same time) Must accept admissions and transfers during report time Results in significant interruption and potential loss of information
Patient dissatisfaction	Waking patient for morning bedside shift report Waking them frequently is the biggest complaint from patients Patients don't understand a lot of the information presented, especially confused patients

Communication Boards



Nurses' Wish List

- Need a consistent method and consistent content so that everyone is on the same page
  - "No one" uses the SBAR form
  - Current computer form doesn't help with consistency and is too long
- Need a dedicated report time for patient safety
  - We don't see the new admission for quite awhile until report is done
  - Potential loss of essential information due to the long interruption from giving report

Nurses' Wish List con't.

- Stagger shift start times for charge nurses, nurses, and CNAs
  - That way someone is on the floor to answer call bells so those getting report are not interrupted
  - Everyone holds out waiting for someone else to answer the call bells because we want to finish report
- Start report away from the bedside, such as at a computer, and then round reviewing communication board and doing safety checks

Recommendations

- Hospital policy providing specific expectations of bedside shift report including the communication board
- Nurse-led work group to determine essential information to pre-populate computer-generated report sheet
- Consider the possibility of a dedicated report time from 7:00-7:30 and investigate if there would be an impact on ED throughput
- Stagger start times to free up staff to answer call bells and limit interruptions to those giving and receving report

Conclusion

- Many barriers identified
- Some consistent with the literature, and some new knowledge
- Develop a workshop that will address barriers

Curriculum for workshop on bedside shift report

Topic	Content	Method	**Time**
Communication skills	Communication defined Non-verbal communication Active listening Relationships in communication Decoding the message	Didactic	1.5 hours
Case scenarios	Confidentiality and sensitivity Incomplete or ineffective report Lengthy report Unprotected time for report Patient satisfaction	Class discussion	1 hour
Role-playing case scenarios	Group role-playing of case scenarios	Role-playing	1 hour
Rehearsing the objective	Each group will role-play scenarios with the groups giving feedback and suggestions.	Role-playing and feedback	1 hour

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