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# Examining Nurse Satisfaction with a Bedside Handover Report Process

Imelda C. Principe
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# Walden University

College of Health Sciences

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Imelda Principe

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Review Committee
Dr. Andrea Jennings-Sanders, Committee Chairperson, Health Services Faculty
Dr. Sophia Brown, Committee Member, Health Services Faculty
Dr. Janice Long, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2017

Abstract

# Examining Nurse Satisfaction with a Bedside Handover Report Process

by

Imelda C. Principe

MSN, University of Phoenix, 2005
BSN, Manila Central University, 1979

Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

Walden University

April 2017

Abstract

Nurses' job satisfaction affects work performance at the point of care in hospitals. The incoming nurses who are able to receive a comprehensive patient report at shift change are more prepared in comparison to incoming nurses who are not able to receive a comprehensive patient report to provide care that is safe. The purpose of this project, guided by the theory of organization change, was to explore whether the use of a bedside handover process impacts nurses' satisfaction in an adult postoperative orthopedic and spine unit. A postimplementation survey of the bedside handover process was conducted after one month and two months to examine registered nurses' (RN) ($n$ = 50) satisfaction using a 7-question self-designed instrument with a reliability coefficient of 0.80. The Bedside Handover Report Staff Nurses' Satisfaction Survey consisted of 5-item Likert scale with scores ranging from 1 *(strongly disagree*) to 5 (*strongly agree*). The survey results found that RNs were satisfied with the bedside handover report process. Matched-pair $t$ tests revealed significant differences between the first and second months after the handover report process was implemented. Specifically, "Bedside handover report provides time for the incoming RN to verify patient's health issues" ($p$ = .05), "I am satisfied with the handover report process conducted at the patient's bedside" ($p$ = .01), and total score ($p$ = .03) improved from the first to second month. A longitudinal study spanning 6 months to a year is recommended when the project will be implemented in the entire facility. A bedside handover report increases nurse satisfaction because the process allows the nurses to verify and address patient health issues that are essential for positive social change.

Examining Nurse Satisfaction with a Bedside Handover Report Process

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# Dedication

I dedicate this paper to my loving and amazing husband Norman, my two wonderful daughters, Jenise and Ann Marie, and in memory of my loving mother, Leonora. Thank you for your moral support, encouragement, and understanding since I started this challenging journey.

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Section 1: Overview of the Evidence-Based Project

## Introduction

The dynamic nature of the health care industry has created multiple challenges for leaders of health care organizations. One such notable challenge is the standardization of the bedside handover process in the clinical setting. Handover is the integral part of the clinical practice (Riesenberg, Leitzsch, & Cunningham, 2010). Several studies reported that communication failures have often been implicated in adverse patient outcomes with communication breakdowns causing nearly 70% of sentinel events (Johnson, Jefferies, & Nicholls, 2011; Nelson & Massey, 2010; Riesenberg et al., 2010). Patient safety is at risk when there are breakdowns in communicating the relevant information for patient care. Communication among health care providers is thus an essential component of safe and effective care (Evans, Grunawalt, McClish, Wood, & Friese, 2012).

A comprehensive bedside handover report process may impact nurses and patients satisfaction that can be evaluated by quantifying patient safety and quality outcomes. Nurses have the greatest responsibility for the continuity of patient care (Thomas & Donahue-Porter, 2012). Nurses are responsible to deliver care that is safe to achieve the patient's baseline state of well-being. The care that nurses provide is a continuous process that is handed over from shift to shift. Failure to provide a comprehensive handover report may result in medication error, increased incidence of falls, and increased occurrence of complications. In addition, the patient's returning to baseline well-being may be delayed (Baker & McGowan, 2010). A comprehensive handover report prevents the delay of patient care delivery.

Identifying an evidence-based practice (EBP) project to pilot test the bedside handover approach and thereby safeguard patient safety is becoming a necessity. Several studies have shown that a standardized process of handover that is conducted at the bedside can improve patient outcomes (Riesenberg et al., 2010; Street et al., 2011; Sand-Jecklin & Sherman, 2013; Staggers & Blaz, 2012).

Bedside handover report is an intervention that provides the opportunity for the outgoing and incoming nurses to communicate with patient and family effectively. The outgoing nurse introduces the incoming nurse to the patient. The incoming nurse updates the patient and family about the patient's current health status, identifies mutual goals for the shift, asks the patient and family about any concerns about their stay, and updates information on the patient care board that serves as a communication tool among health care providers and patients. This process promotes patient safety and builds trust by allowing patient and families to be active participants during the nurse-to-nurse bedside handover report (Maxson, Derby, Wrobleski, & Foss, 2012).

Communication between nurses becomes more effective during bedside handover report process (Evans et al., 2012). The bedside handover report assures that the incoming nurse will continue to provide care that the outgoing nurse is not able to deliver and complete. A direct visualization of patient and bedside provides the opportunity for the incoming nurse to perform a focus assessment with the presence of the outgoing nurse. Nurses' reports become more real when visualization happens. Nurses are able to visualize patients and implement safety checks at the start of the shift, which facilitates a smoother workflow (Reinbeck & Fitzsimons, 2013).

## Problem Statement

The transfer of patient information between the outgoing and incoming nurses during shift change is crucial for the continuity of care. The failure to communicate pertinent patient information may result in the increased morbidity and mortality of the patient (Maxson et al., 2012; Shendell-Falik, Feinson, & Mohr, 2007). The Joint Commission has issued several safety goal standards that have addressed the issue of sentinel events that result from the failure of health care practitioners to communicate a comprehensive report properly (Evans et al., 2012). Indeed, a bedside handover report process promotes patient safety, which is an essential and vital component of quality nursing care (Ballard, 2003). A comprehensive handover process is an integral part of clinical practice and its utilization is becoming essential for health care organizations to adopt. Nurses are responsible and accountable for performing most of the handover communication daily; however, they are not formally trained on this critical responsibility (Riesenberg et al., 2010). The purpose of handover communication is to provide accurate, up-to-date information about the patient's care, treatment, current condition, and any anticipated changes in the patient's condition (Street et al., 2011). Nurses may be found legally liable for failing to report necessary patient information during handover that may contribute to medical errors (Riesenberg et al., 2010).

## Purpose Statement and Project Objectives

This DNP project explored whether the use of a bedside handover process impacts nurse satisfaction in an adult postoperative orthopedic and spine unit one month and two months after implementation. The bedside handover process is suitable for nurses to prioritize their work because they can visualize all their patients in real time (Maxson et

al., 2012). In addition, several studies have shown that a bedside handover report process improves nurses' awareness of immediate patient needs and concerns and allows them to feel more prepared to discuss patient care issues with other licensed practitioners (Maxson et al., 2012; Sand-Jecklin et al., 2013; Thomas & Donohue-Porter, 2012). Nurses who receive accurate and relevant patient information during a change of shift can provide the continuity of patient care safely.

The objective of this DNP project was to examine nurse satisfaction with a bedside handover report process. Currently, the orthopedic and spine postoperative unit has adopted no specific standard of bedside handover communication. In 2006, the Joint Commission formulated a safety goal that required health care institutions to develop an approach to handover communication processes that should include patient and family participation (Evans et al., 2012). Moving the handover report process at the bedside facilitated a clear transition of responsibility and accountability from one staff nurse to another.

## Significance/Relevance to Practice

The handover process was done by face-to-face verbal communication, taped or recorded, and/or in a written format (Maxson et al., 2012). In addition, the handover process was performed anywhere on the nursing unit except at the bedside. Hence, patients and families were not included in the handover process and may not even be updated or informed about a change in their care arrangements.

In 2009, the Joint Commission mandated health care organizations to involve patients and families in decision making and providing input with their daily plan of care (Maxson et al., 2012). Moving the handover process to bedside during a change of shift

made it possible for patients and families to be involved and engaged with the provision of care. Moreover, patients and families are encouraged to actively participate in the plan of care during the bedside handover process. Studies have shown that moving the handover report to the bedside and encouraging patient participation fosters a sense of respect and trust between patient and nurses, allowing for more accurate exchange of information (Reinbeck & Fitzsimons, 2013; Maxson et al., 2012; Thomas & Donahue-Porter, 2012). Thus, this process benefited and enhanced the safety and quality of patient outcomes.

The incoming nurse reviewed the patient's medical record at the initial phase of the registered nurse-to-registered nurse (RN) handover process outside the patient's room. Then, patient and family got involved in the second phase of the handover process when the outgoing and incoming nurses interacted with them at the bedside. Violation of patient privacy with bedside report was a common concern among nurses, thus, the patient was given a choice whether a family member could stay at the bedside during the handover process (Sand-Jecklin & Sherman, 2013).

Nurses' job satisfaction affected work performance at the point of care. The incoming nurses who were able to receive a comprehensive patient report are prepared to provide the care that is safe and satisfactory. A handover process that gives the incoming nurse the opportunity to ask questions and clarify patient care issues with the outgoing nurses enhances their skills to prioritize the care that they have to provide. The bedside handover process has significant impact on patient safety but also impacts satisfaction outcomes on communication, collaboration, and team efforts among nurses (Thomas & Donahue-Porter, 2012).

## Problem Question

The DNP project question was: Will a bedside handover report result in nurse satisfaction at one month and two months postimplementation?

## Evidence-Based Significance of the Project

Ineffective handovers can be a hazard to patients and staff leading to irrelevant, repetitive, and speculative information being communicated during shift reports and resulting in the misuse or poor utilization of resources (Street et al., 2011). Constant changes in the health care environment pose challenges and make it difficult for nurses to provide the best care. Nurses must be supported to survive the challenges and dynamics of the health care environment.

The responsibility and accountability for providing safe and quality care is fundamental for nursing professionals. Nurses in every clinical setting feel a sense of accomplishment and satisfaction when patients and families are satisfied with the nursing care provided in every encounter. In other words, patient satisfaction results in a nurse experiencing satisfaction in the workplace.

Health care organizations are changing visions, strategies, and operational procedures to reduce medical errors and improve the quality of care while at the same time controling costs (Bohmer & Knoop, 2007). The Institute of Medicine recommended the use of a patient-centered care delivery system. Patient-centered care is defined as "providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (Institute of Medicine, 2001, p. 6). The participation of patients during the bedside handover made this process a patient-centered care approach.

## Implications for Social Change

The bedside handover process provided the opportunity for the nurses to be effective communicators. Nurses as patient advocates have the responsibility to speak on behalf of their patients and families who may have limited knowledge and information regarding their diseases and treatments. Nurses act both as change agents and as supporters/advocates who can assist people to adapt to the myriad of changes that affect their lives (Kaminski, 2014). Through effective communication skills, nurses may advocate for their patients and families in seeking the assistance that they need to recover during hospitalization.

Nurses, who represent the largest group of health care providers in any given setting, are responsible to assess the needs of the community and its aggregates. Depending upon their professional practice and specialty, nurses may use their communication skills to represent the public in terms of health care needs, appeal for health promotion funding, and the availability of health care facilities and providers in the remote areas. Nurses are in the unique position to facilitate new development both as activists and agents of change, guides and advocates for individuals, groups, and communities working for change and social justice (Kaminski, 2014).

## Definition of Terms

*Handover communication:* The process of communication performed by health care providers, especially staff nurses, at the beginning and end of shifts, relieving breaks, transfers of patient care services, and changes in a patient’s conditions. This process of communication can be done within patient care units but not necessarily at the

bedside. The process of communication can be verbal, written, and/or recorded (Evans et al., 2012; Street et al., 2011; Maxson et al., 2012).

*Bedside handover report:* The process of handover communication to be done at the bedside by staff nurses at changes of shifts, relieving breaks, and changes in a patient's condition. Handover communication includes the following processes: (a) the incoming nurse reviews the patient's history and information in the electronic medical record; (b) the outgoing nurse introduces the incoming nurse to the patient and family; and (c) the incoming nurse physically checks the patient, updates the care board with the names of the health care providers and the patient's goal for the day, and assesses the patient's bedside environment for safety (Evans et al., 2012; Maxson et al., 2012; Staggers & Blazz, 2012).

*Patient safety:* The state or condition when patients are free from injury, illness, and/or disability during hospitalization under the care of health care providers due to the prevention of medical errors with the use of the bedside handover report process (Sand-Jecklin & Sherman, 2009).

*Nurses' satisfaction:* A state of well-being when staff nurses demonstrate contentment with their roles resulting in excellent patient outcomes. Several studies have demonstrated a positive association between employee job satisfaction and quality care (Aiken, Clarke, & Sloane, 2002; White & Dudley-Brown, 2012; Nelson & Massey, 2010; Maxson et al., 2012).

*Nursing clinical handovers:* "The transfer of professional responsibility and accountability for some or all aspects of care for a patient or group of patients to another person or professional group on a temporary or permanent basis" (Johnson et al., 2011, p.

332). Clinical handover (sometimes referred to “handoff” in North America) is a “universal procedure used by nurses to promote continuity of care” (Poletick & Holly, 2010, p. 122).

*Patients' satisfaction:* A state of well-being when patients feel comfortable and assured that everyone in the health care team is receiving the necessary report about them and feel more informed about their care, which makes them less anxious and more compliant with their plan of care (Baker & McGowan, 2010). Patients are satisfied when they feel like they are in “safe hands” knowing that everything about their health status is being monitored continuously with their participation (Radtke, 2013; Baker & McGowan, 2010; Thomas & Donohue-Porter, 2012).

**Assumptions and Limitations**

The commitment that upholds health care organizations and their providers is the intention to provide the best quality care for all patients. Constant changes in the health care environment challenge staff to adapt and use the best EBPs available to promote patient-centered and quality care. Health care organizations are encouraged to choose the best practices that can involve patients and families to participate in the delivery of care and to optimize their health status during the period of hospitalization.

The assumption of using the bedside handover process as an EBP could impact nurses' satisfaction. With the participation of patients and families in identifying their goal at the start of the shift, nurses were able to plan safer and better care as well as prioritize patient care activities. The bedside handover report has the potential to decrease medication errors as well as to enhance communication among nurses, physicians, patient and family, and other health care team members to promote and encourage an

environment that emphasizes patient safety and quality care (Maxson et al., 2012). The safety of patients is always central.

The limitations of this DNP project included the use of a convenience sample of staff nurses working in an orthopedic and spine postoperative unit. This acute care bed setting may not represent findings that are applicable to other patient care settings in a facility such as rehabilitation, pediatrics, critical care, and perianesthesia care units.

## Summary

The scope of this DNP project was focused on presenting and adopting an evidence-based best practice in the RN-to-RN handover report process. The handover report process is integral to nursing practice and the need for its improvement is well recognized (Thomas & Donohue-Porter, 2012). Nursing researchers have reported improved communication between outgoing and incoming nurses through the use of the bedside handover process (Evans et al., 2012; Sand-Jecklin & Sherman, 2013; Thomas & Donohue-Porter, 2011; Clarke, Squire, Heyme, Mickle, & Petrie, 2012; Benson Rippin-Sisler, Jabusch, & Keast, 2007; Alvarado et al., 2006).

# Section 2: Review of Scholarly Evidence

A search of the literature regarding the bedside handover report process was conducted over a period of four months by using electronic databases as the primary data source. The key words *bedside handover* were entered into CINAHL, the Cochrane Database of Systematic Review, Google Scholar, Medline/Ovid, Proquest, and PubMed by using the Walden University library. The initial search yielded over 100 articles.

Realizing that the search was too broad, a second literature search was narrowed using the Boolean operations. The Boolean words include the following terms: *bedside handover and nurse's satisfaction, bedside handover and nursing, bedside handover and patient satisfaction,* and *bedside handover and patient safety*. The second search was limited to articles written in English that were published from 2005 to the present.

## Literature Review

Staggers and Blaz (2012) conducted an integrative review of the literature with a purpose of synthesizing outcomes on handoff studies to guide future processes on medical and surgical units. Compared to systematic reviews that include only quantitative studies, an integrative review method includes all study designs while adhering to rigorous review processes (Whittemore & Knafl, 2005). The integrative review of the literature included studies from 1980 to March 2011. The search strategy yielded a total of 247 references. Eighty-one studies were retrieved, read, and rated for relevance and research quality; a set of 30 articles met relevance criteria. The authors have concluded that a bedside handover report process could be delivered in any format as long as it was designed to provide safe and quality care, prevent error in communication, and promote staff satisfaction with its use. The handover process should be highly tailored to the

clinical setting and its end-users' contextual needs in order to determine information critical to accurate and complete handoffs (Brown, 2007; Benham & Effken, 2010; Chaboyer, McMurray, & Wallis, 2010). Verbal and face-to-face handoffs serve important functions beyond information transfer and should be retained to provide support for error-detection and dispelling erroneous assumptions (Fenton, 2006; Anderson & Mangino, 2006).

Street et al. (2011) conducted a study of nurses' experience and perspective of handover communication at the bedside to enhance patient care. The purposes of the study were to identify strengths and limitations in the current practice of nursing clinical handover and implement a new bedside handover process in Australian public hospitals. A cross-sectional survey of staff nurses was conducted three months after the pilot study of implementing a bedside handover process. Overall, 259 (74%) nurses completed the survey, of which 91% were female, 50% were Division 1 nurses, 51% were part-time, and 45% were morning shift staff (Street et al., 2011). Eighty percent (80%) of nurses agreed that sufficient and up-to-date patient information was provided during shift change, they were able to clarify information, and they had an opportunity to ask questions during handover (Street et al., 2011). Preliminary findings stated that improvement in practice was noted after the implementation of the process and required a long-term evaluation to prove its success.

Evans et al. (2012) conducted a study of implementation and outcomes of bedside shift-to-shift nursing report. The purpose of the study was to solve the issue of staff dissatisfaction with nurse-to-nurse report and the inability to complete the shift at the scheduled time. The unit-based team nurses from University of Michigan Hospital and

Health Centers had reviewed the literature for best practice and identified bedside shift report as one strategy to improved desired outcomes. A benchmarking analysis with peer units and across institutions was performed to identify options for nurse-to-nurse report formats. A script was generated to standardize the content of the report. Staff nurses completed a Satisfaction with Shift-to-Shift Nursing Report survey two weeks after implementation of the bedside handover report. Findings of the study suggested that bedside handover report increased nurse satisfaction, helped nurses to prioritize their workflow better, and decreased amount of time for report (Evans et al., 2012). Greater nurse satisfaction was achieved by receiving a more comprehensive report without distractions. Patient-centered care was also strengthened since patients got involved with their plan of care.

Maxson et al., (2012) conducted a study relating bedside handover report process to promoting patient safety. The purposes of the study was to determine if bedside nurse-to-nurse handoff increases staff satisfaction with communication and accountability, increases patient satisfaction with the plan of care, increases patient perception of teamwork. Staff nurses were surveyed before and after the implementation of the process. Survey questions were used to measure changes in accountability, adequacy of communication at change of shift, prioritization of workload, performance of medication reconciliation, and ability to communicate with other health care workers after handoff. An investigator-developed survey was used to collect data from 30 patients before implementing bedside nursing handoff, and another 30 patients 1 month after bedside handoff was implemented. Survey questions addressed patients’ perception of the following: (a) open communication between members of the health care team about plans

of care, (b) patients' satisfaction with the amount of input they had in their plans of care, and (c) patients' perception of the professionalism and confidential manner used in the reporting between care providers. Scores on the pre-implementation included means of 2-4, with nurse-to-nurse accountability, medication reconciliation, and ability to communicate immediately with physicians regarding patient care after shift handoff receiving the lower rankings. The postimplementation survey resulted in all questions receiving a mean score of 1 (best). Every question in the survey had statistical significance ($p < 0.05$) with the exception of one: prioritizing the workload ($p = 0.06$; Maxson et al., 2012). The patient survey results had mean scores before the practice change ranging from 1.5 to 2; all scores after the practice change had a mean of 1; significance was noted referring to patients being informed of their plans of care for the day ($p = 0.02$; Maxson et al., 2012). Findings of the study concluded that patients' participation in change-of-shift discussions with the nurses has the potential to decrease medication errors and enhance communication among health care team members, patients, and family that promotes and encourages an environment emphasizing patient safety and quality.

The Medical Surgical Research Utilization Team at West Virginia University implemented bedside reporting to evaluate process and outcomes in terms of effectiveness, efficiency, patient and staff satisfaction, and impact on patient safety. Baseline data on nurses' satisfaction with the shift report were collected online after one month and three months after implementation of the practice change. An open-ended survey was conducted after three months of the study. Paired *t*-test comparisons were made between baseline and postimplementation of the project, and descriptive analysis

was conducted evaluating the open-ended survey. The open-ended survey nurses stated that bedside report improved accountability and increased patient involvement. Independent *t* test indicated a significant difference between baseline and postimplementation scores, which suggested that bedside handover report was (a) an effective and efficient means of communication, (b) stress free, (c) a means of preventing delays in patient care or discharge, and (d) completed within a reasonable amount of time (Sand-Jecklin & Sherman, 2013). Baseline data collected on patient satisfaction examined topics such as (a) treating the patient with respect and in a kind way, (b) listening carefully, (c) informing the patient about care, (d) teaching in a manner the patient could understand, (e) working well together, (f) communicating important information from shift to shift, (g) including the patient in report discussions, and (h) keeping health information private. Implementation of a bedside handover process resulted in improved nurses' perceptions regarding accountability and patient involvement in care. The study reported that lower medication errors (a 50% reduction rate) and fewer patient falls at shift change (a 35% reduction rate) resulted (Sand-Jecklin & Sherman, 2013). The Patient Views on Nursing Care Survey respondents were highly satisfied with nursing care after the implementation of the bedside report. The findings (Sand-Jecklin & Sherman, 2013) included with the following data: (a) "include in shift report discussion" (mean: preimplementation, 4.0; postimplementation, 4.3), (b) "tell you about plans for discharge" (mean: of 4.2 pre and 4.4 postimplementation), (c) "treat you in a polite, kind way" (mean: pre and postimplementation, 4.7), (d) "treat you with respect" (mean: preimplementation, 4.6; postimplementation, 4.7), and (e) "staff work well with each other," "nurses listen carefully without interrupting," and "keep health

information private" (mean: 4.6 pre and postimplementation). The findings of the study included an overall reduction of adverse events, which is of clinical significance. Patients were satisfied with improved information flow and good communication between patients, families, and nursing staff.

Ineffective handoff has been identified as a barrier to patient safety and quality. The study conducted by Thomas and Donohue-Porter (2012) addressed the blending of evidence and innovation for the improvement of the intershift report. The purpose of the study was to standardize nursing practice across the hospital systems aligning with the Joint Commission requirements of minimizing the risk of error related to ineffective communication during shift change. A nursing research team redesigned the intershift report. Team strategies and tools to enhance performance and patient safety (TeamSTEPPS) was tested in addition to the bedside handover report process to improve communication and teamwork and promote mutual respect among all team members. Patient satisfaction was measured using the Press Ganey Inpatient Survey. Seven hospitals within the system were reviewed. Specific feedback during the process of implementation using narrative reports and nurses' responses were consistent, as follows: (a) two RNs evaluated a room set up for emergencies, (b) nurses became more accountable to leave the bedside in order, and (c) experienced nurses were able to teach novice nurses during rounds. Patient satisfaction scores improved with the implementation of the bedside handoff process, which was validated with 3 patient satisfaction surveys and considered to be an exemplar of a successful implementation of the bedside handover report process among the seven hospital participants. The authors concluded that the bedside handover report process had a profound significance for

nursing, not only on its potential impact on patient safety, but also in its investigation of patient satisfaction outcomes, communication, collaboration, team work, and promotion of patient-centered care.

Nelson and Massey (2010) conducted a study with a purpose of developing, testing, and implementing an electronic template and process for the change-of-shift report associated with the transforming care at the bedside (TCAB) model. Predicted outcomes were identified as follows: (a) reduction in time spent in change-of-shift reports, (b) reduced end-of-shift overtime, and (c) a standardized process perceived by staff to be improved regarding information quality and overall staff satisfaction with the process. The organization began the process by designating two inpatient pilot units using rapid-cycle tests of change using the *plan, do, check, act* model as the basis of testing improvement. The rapid-cycle testing lasted approximately one week, with changes to the template and processes based on staff feedback after each cycle. Seven rapid-cycles tests took place over a 2-month period. After completion of the study, the authors reported that using the TCAB model increased staff satisfaction associated with leaving on time, report process efficiency, and patient information being useful and updated. The TCAB model provided the opportunity for the nurses to visualize patients at change of shift. An electronic shift report template led to sustained improvement in the change-of-shift process. Nurses' satisfaction was noted as the reporting process became more focused and timely. Cost savings were also achieved as reported.

Matic, Davidson, and Salamonson (2010) conducted an integrative review with a purpose of examining different methods of handover delivery and usability of electronic handover system in healthcare settings. A total of 304 sources were retrieved and 126

published articles in relation with the topic were identified. Studies have shown that handover is vital in building good morale and facilitates cohesiveness of the nursing unit (Lally, 1999). However, the process needs to be improved for it lacked structure with the potential for irrelevant and subjective information (Webster, 1999; Sexton et al., 2004). Matic et al. (2010) concluded that clinical handover has to undergo increased scrutiny, development, and research. There are multiple methods of nursing handover but literature lacked studies to identify the contents and standardization of the process.

Riesenberg et al. (2010) conducted a systematic review with the purpose of identifying barriers and strategies for effective handoffs. English-language articles published only in the US between January 1987 and August 2008 were reviewed. There were 460 published articles obtained for further review. Ninety-five articles met the inclusion criteria and were published between January 1, 2006 and August 4, 2008. The majority of the research studies on nursing handoffs received quality scores at or below eight and only three achieved scores above 10. Only ten peer-reviewed studies included measures of handoff effectiveness (Riesenberg et al., 2010). Based on this systematic review, the researchers found out that very little research has been done to identify best practice. The researchers called for high-quality studies of handoff outcomes that focus on system factors, human performance, and the effectiveness of structured protocols and interventions (Riesenberg et al., 2010).

Johnson et al. (2011) conducted a study about a minimum data set designed for an electronic system to complement verbal nursing handover. Patient handovers ($n$ = 195) were observed and digitally recorded across diverse specialties. Content analysis confirmed the frequent use of Nursing Handover Minimum Data Set items across

specialties. The authors concluded that nurses preferred the use of Nursing Handover Minimum Data set items to facilitate the process of handover. Using predetermined items to communicate during handover report provide relevant and accurate information in a reasonable amount of time. However, the data need to be flexible and adaptable to the patient context and setting to complement the method of handover report process.

Radtke (2013) performed a study about improving patient satisfaction with nursing communication using bedside shift report. The objective of the study was to determine if standardizing bedside shift report might improve patient satisfaction scores. A pilot bedside shift report process was developed on a medical/surgical intermediate care unit to improve patient satisfaction scores in the area of “nurse communicated well” with the goal of reaching 90% satisfaction rates and was presented to a 16-bed medical/surgical intermediate care unit at a 320-bed tertiary-care facility. Patient satisfaction scores was complied quarterly and provided the basis to adopt the change of moving centralized reporting to patient’s bedside. An average of 25 patients participated in the survey across the organization per quarter for an average of 100 patients surveyed internally for the organization. Monitoring patient satisfaction was continued for three months. The results had shown that there was a rise in patient satisfaction in nursing communication to 87.6%, an increase from 75% in the previous 6 months (Radtke, 2013). Although, the scores did not meet the goal of 90%, but the pilot program did show that the bedside handover report process did impact patient satisfaction. Findings of the study concluded that bedside shift report could improve handover communication to improve patient safety, an approach to patient care that can enhance patient satisfaction through communication.

## Conceptual Models/Theoretical Framework

The theoretical framework or model most appropriate for this DNP project is the theory of organizational change. This theory is based on Kurt Lewin's Theory of Change and Rogers' Diffusion of Innovation Theory. This theory is applied to the whole organization, where all people are involved in the adoption of the proposed change by going through steps or stages. Steckler, Goodman, and Kegler (2005) stated that the theory of organizational change "explains how organizations innovate new goals, programs, technologies, and ideas" (cited in Hodges & Videto, 2011, p. 151). Pfeffer (2002) summarized the theory of organizational change as "an interdisciplinary focus on the following: (a) the effect of social organizations on the behavior and attitudes of individuals within them, (b) the effects of the individual characteristics and action on organization, (c) the performance, success, and survival of organizations, (d) the mutual effects of the environments including resource and task, political, and (e) cultural environments on organizations and vice versa" (cited in Van de Ven & Poole, 2005, p. 20).

The theory of organizational change is applicable to this DNP project since the organization needed to recognize and prioritize the satisfaction of its employees, in this case, staff nurses. Increased nurses' job satisfaction leads to increased patient satisfaction. Nursing leaders must also be involved to support nursing professionals at the point of care. The involvement of all nursing personnel from top to bottom positively influences patient care by, (a) supporting and motivating staff nurses to adopt EBP in patient care, (b) establishing positive relationships with nurses that empower to recognize the need for the handover to provide reliable and accurate patient information, and (c) establishing

positive working relationships and teamwork that lead to the implementation of an EBP with the delivery of quality patient care.

Glanz and Rimer (2005) had mentioned the four basic stages of organizational change, namely, problem definition (awareness), initiation of action (adoption), implementation, and the institutionalization of the identified change (cited in Hodges & Videto, 2011, p. 151). An assessment of the forces, both driving and restraining, throughout the change process is necessary to recognize their power and to involve all individuals in the organization, build trust, encourage a new view, and to integrate new ideas into the organization (White & Dudley-Brown, 2012). Implementing change should involve the support of all nursing personnel at all levels.

Table 1

*The Theory of Organizational Change*

| | |
|---|---|
| 1. Problem definition (awareness) | -Decreased nurse-nurse communication<br>-Increased in medical errors |
| 2. Initiation of action (adoption) | -Search for EBP on handover report<br>-Analyze and synthesize EBP literature<br>-Present EBP on bedside handover to stakeholders |
| 3. Implementation | -Decision to pilot the bedside report process in a specific nursing unit (initial)<br>-Identify participants of the project<br>-Train the trainers on the bedside handover<br>-Implement the EBP project<br>-Evaluate the bedside handover process after a month<br>-Presentation of results to stakeholders<br>-Modification of the bedside handover report process based on the evaluation |
| 4. Institutionalization of the identified change | -Adoption of the bedside handover report process<br>-Training the nursing staff<br>-Implementation of the bedside handover report<br>-Evaluation through clinical observation (peer review) to sustain practice |

All factors that affect patient care and patient safety must be addressed comprehensively. One aspect of patient care that directly related to patient safety is a handover report process. Improving handover report process is everybody's responsibility.

The participation of stakeholders at all level is important to accomplish the goal to adopt a best practice in handover report process. Organizational readiness for change is a multi-level, multi-faceted construct (Wiener, 2009). Change is difficult to attain without the buy-in of the stakeholders. Adopting change is a team effort for it affects everyone in the organization.

Erwin (2007) conducted a study examining the change process in a health care organization. The study lasted for two and half years observing the process of organizational change in an institution and how the theory of organizational change contributed to its success of adopting and sustaining the change needed to transform the organization facing financial challenges. The top leader of the organization used the theory of organizational change to incite the participation of all employees in adopting the change needed to retain the viability of the organization. Kotters (1995, 1996) has suggested that influencing change involves empowering others to act, removing obstacles, creating short term wins, consolidating improvements, and institutionalizing new approaches (cited in Erwin, 2007, p. 39). The initial process applied by the leader is the first stage of the theory (problem definition or awareness). All employees are made them aware of the current situation and updates were provided constantly through emails, newsletters, and staff meetings of the senior management, governing councils, and staff. The message was accepted and perceived by all employees to be honest and transparent

(Erwin, 2007). During the 2.5 year period between January 2006- June 2008 despite a 2% decline in admissions and an 8% in increase in care-mix index, the hospital's financial performance improved, reduced annual expenses by over $6,300.000, decreased employees' turnover, patient satisfaction and employee satisfaction remain stable, and all patient core measures were remarkably increased (Erwin, 2007). The indication of a team approach in adopting change is essential for the success of the organization.

Ardern (1999) conducted a grounded theory study of organizational change in England. This study was based in adopting a change of practice in caring for patients with dementia. Interviews and observations took place over a period of two years. Initially, staff nurses were involved with the development of policies and procedures. However, their initiatives did not materialize and failed to be recognized by their immediate supervisors. From this point the team became increasingly isolated from the organization and lost direction (Ardern, 1999). Failure to engage the staff nurses by isolating them resulted to disempowerment and prevented them to actively involve in the process of working together as a team. Limited communication with the staff nurses resulted to low esteem and low moral as they felt to be alienated by the system. Withholding of information, a "method of holding the power", and poor communication flow inhibited the staff nurses' opportunities to integrate and participate continuously in adopting the change necessary in improving the care in this clinical setting (Ardern, 1999). As indicated in this study, there was a clear relationship in adopting change, organizational support, and the staff nurses' ability to act effectively.

Stakeholders at all levels can be empowered supporting each other in adopting change to improve the delivery of care. In this project, the support of the organization and

nursing leadership is necessary to adopt best practice and sustain the change needed in improving the handover report process. Change efficacy is higher when people share a sense of responsibility and confidence collectively that they can implement any organizational change anytime when it is needed (Weiner, 2009).

As indicated in Table 1, the different stages of the theory will be applied in this DNP project from problem definition (awareness) up to the institutionalization of the identified change. Each stage represents the participation of stakeholders from consultation, approval of the project implementation, and decision of adopting the practice change.

# Section 3: Approach

## Project Designs and Methods

Relation Based Care (RBC) is the model of healthcare delivery that identifies the three fundamental relationships that define patient experience: the nurses' relationships to self, to colleagues, and to patients and families (Koloroutis, 2004). Patients' lengths of stay are decreasing and the need to establish a strong relationship between patients and nurses is essential to promote healing and recovery through communication and collaboration.

Nursing excellence has to be practiced every day. In an RBC culture, nurses get reconnected with the purpose and meaning of their work. Teamwork is based on deep commitment rather than surface-level compliance, and patients and their families feel safe and cared for by nurses who commit themselves to making authentic human connections with the people in their care (Felgen, 2013).

The bedside handover approach was chosen by the nursing leaders to reflect the health care delivery model where staff nurses are able to establish better relationships with other health care team members, patients, and families. Communication and strong collegial relationship are needed to create an environment for patient safety (Koloroutis, 2004). The bedside handover approach is also an excellent way to build teamwork, ownership, and accountability among nurses that is vital to patient safety (Baker & McGowan, 2010).

**Bedside Handover Report Implementation Plan**

Staff nurses were trained a month before the implementation of the bedside handover report. The training strategies included two teaching methods: (a) lecture with discussion and (b) role play/simulation.

Lecture with discussion was conducted for thirty minutes in a classroom setting. I developed a PowerPoint presentation about bedside handover report process (Appendix C). The lecture included the following discussion: (a) reasons for changing the handover report process, (b) desired outcomes of using bedside handover report, (c) advantages of bedside handover report, (d) staff training methods, (e) review of patient's medical record using the DATA (demographic, assessment, treatment, action) format (Appendix D), and (f) elements of focus assessment during the bedside handover report process. During classroom discussion, each learner was given the opportunity to ask questions to clarify the process of bedside handover report.

After the lecture with discussion session, a role play/simulation method was conducted. Through the role play/simulation method, staff nurses were able to play the roles of incoming and outgoing nurses simulating the bedside handover report process. A script was provided to staff nurses for role-play to perform bedside handover reports under my supervision as DNP project leader in a classroom setting (Appendix E). I conducted daily clinical rounds during the implementation of the bedside handover process at shift change for two months. Additional workstations on wheels (computers) were made available to be used by the incoming nurses to avoid delay of reviewing a patient's medical records during shift change in order to facilitate the initial step of the handover process. Staff nurses were advised to use the DATA format tool to obtain

patient information in the electronic medical record (EMR). Technical support was provided to staff nurses who had difficult time finding patient information in the EMR.

**Handover Report Process**

The previous handover report process during change of shift occurred in the nurses' station. A verbal report was provided by the outgoing nurse, and the incoming nurse wrote patient information manually in a printed nurse worksheet. Verbal report can be lengthy and interrupted at times. The handover report process took place even when nursing documentation was incomplete. At times, medical orders were missed, care plan and patient education were not updated, and medication administration record was not completed.

The incoming nurse conducted bedside assessment alone, verified medication/IV pump settings, and solely updated the patient regarding their current health status based on the report received from the outgoing nurse. The patient was not involved with the handover process resulting in a decrease of patient satisfaction with regard to communication with nurses and care transitions.

**Bedside Handover Report Process**

The outgoing RN performed hourly rounding an hour before the shift ended. The RN assessed the patient's needs, addressing pain, position, potty, and possession. Patients and family members were informed and educated regarding the bedside handover report process. Patients and families' questions and concerns about the handover process were also addressed at this time to encourage participation in managing the plan of care.

The incoming RN solely reviewed the patient medical record using the DATA format via the health information technology system. DATA format provided a

mechanism useful for reviewing the patient's information that is focused and concrete. The demographic section review includes the following: (a) medical and surgical history, (b) allergy, (c) do-not-resuscitate (DNR)/do-not-intubate (DNI) status, (d) advanced directives, and (e) patient's preferred spoken language. The assessment section includes: (a) patient care summary; (b) patient profile including risk assessment, falls, skin, suicide, Audit C (alcoholism); (c) presence of medical devices; (d) review of medication administration record; and (e) lab reports. Treatment section includes review of care plan and patient education documentation. The action section includes the following: (a) latest medical orders, (b) discharge planning/discharge instructions, (c) medication reconciliation, and (d) patient concerns that need to be addressed (if any). The incoming RN reviewed all required documentation and reminded the outgoing RN to complete such before the end of the shift. If there were any clarifications about the patient status, the incoming RN were able to verify with the outgoing RN during the initial phase of the handover report process. After the medical record reviews, the outgoing and incoming RNs then proceeded to the patient's bedside and completed the handover process. The outgoing RN introduced the incoming RN to patient and family (if allowed and present). The incoming RN performed a focus assessment at the bedside checking the following: (a) patient's ID (physical and verbal), (b) surgical wound dressing and drainage (if any), (c) skin condition, (d) intravenous sites, dressings, and presence of labels, and (e) medication pump settings for accuracy verification. The incoming RN defined goals with the patients for the shift, reviewed the plan of care with each patient, and addressed each patient's needs and concerns.  Care board information were updated by the incoming RN with the following: (a) names of health care team members; (b) pain medication

schedule; and (c) treatment and procedure schedule, for example, physical therapy (PT), occupational therapy (OT), X-rays, magnetic resonance imaging (MRI), computer tomography (CT) scan, and so forth.

## Population and Sampling

The pilot study of implementing the bedside handover process was done in the orthopedic and spine nursing units of the hospital. This is a 42-bed medical-surgical unit of the facility that takes care of immediate postoperative orthopedic and spine patients. The staff nurses of the orthopedic and spine unit were the target population of this DNP project. The target population was 25% of the RN working in the acute care unit. This consisted of staff with a BSN degree, both male and female, novice and expert nursing practitioners, who worked day, evening, and night shifts and participated voluntarily with the study. A convenience sample of 50 registered nurses was invited to participate. All participants completed the survey at 1 month and 2 months postimplementation of the bedside handover report.

## Data Collection

I conducted a postimplementation of the bedside handover process survey after a month and two months to examine the impact of its use related to nurses' satisfaction. A 7-question self-designed instrument was used to gather data using a Likert scale. The Bedside Handover Report Staff Nurses' Satisfaction Survey was a 5-item Likert scale with scores ranging from 1 (strongly disagree) to 5 (strongly agree). An instrument development expert was consulted to review the contents of the self-designed instrument for validity. The bedside handover report survey was piloted in the hospital with twenty

RNs who participated and completed the survey. The result had shown the reliability coefficient of 0.80 that indicated positive relationships between the variables.

Assessing nurses satisfaction using the bedside handover report process, the self-designed instrument addresses the following: (a) provided up-to-date patient information between incoming and outgoing RNs at change of shift, (b) RN able to prioritized patient care activities, (c) verified patient's health issues that needs to be addressed for the incoming shift, (d) promoted comprehensive communication between the outgoing and incoming RNs resulting to a safer patient care delivery, (e) ensured RNs' work accountability, and (f) minimized delays in providing patient care. The survey was sent through email for staff nurses convenience. Participants were verbally reminded to complete the 2 months survey. Additional space for staff nurses' comments and suggestions was included at the end of the survey. Three participants have written suggestions that comprised of the following: (a) patient assignments needed to be known before shift change, (b) constant use of computers for obtaining patient information, and (c) both RNs must be at the bedside during patient's verification. A demographic profile of the participants was included in the survey which included the following: (a) gender, (b) age, (c) years of nursing experience, and (d) working hours (shifts).

First, prior to IRB approval, the structure of the proposed project was presented to the chosen pilot site during the unit practice council meeting. Nursing leaders and unit practice council members were invited to attend staff meetings. Additional information about the proposed project was sent through email to all RNs working at the chosen pilot site.

Second, after IRB approval from Walden University (03-23-16-0320589), as the project leader, I attended and discussed the project at unit-based staff meetings. During these meetings, the plan for the project was outlined and the criteria for the participation were reviewed. Nursing staff was invited to participate in the study through a letter of invitation. In addition, I informed the nursing staff that participation is voluntary and participants can withdraw anytime during the duration of the project. Informed consent was obtained from all participants.

## Data Analysis

To explore the DNP question, the use of a quantitative research design was pertinent to measure the outcomes of the bedside handover report project related to nurses' satisfaction. One month after bedside handover report process implementation, nurses' satisfaction was assessed using the self-designed survey questions. Nurses were surveyed again two months after the implementation of practice change. A *t* test was used to examine nurses' satisfaction. The data collected were analyzed with the assistance of a data analyst who used SPSS.

## Project Evaluation Plan

The purpose of the bedside handover report project was to assess nurses' satisfaction with the use of the handover report process. A survey was conducted after a month and then two months of project implementation. I conducted a formative evaluation during the initial phase and a summative evaluation after two months of project implementation. The interpretation of the findings will be shared with Nurse Practice Council and Research and EBP Council upon completion of the bedside handover report project. The findings of the bedside handover report project will be used

to implement the bedside handover report process throughout the facility. Poster and podium presentations and publication are being considered to disseminate the findings to other nursing communities.

## Summary

The use of a standardized bedside handover report process can prevent communication gaps between incoming and outgoing nurses. Furthermore, patient care is becoming complex, nurses needed an effective handover report process which is an essential component of safe and excellent care. Bedside handover report project have significance for nursing practice, not only on its potential impact on patient safety but also in its correlation with its patient satisfaction outcomes, effective RN-to-RN communication, and team collaboration.

## Section 4: Discussion and Implications

### Summary of Findings

The purpose of this DNP project was to explore whether the use of a bedside handover process impacted nurses' satisfaction in an adult postoperative orthopedic and spine unit. The changes in seven statements and their total scores from month one to month two were surveyed from a sample of 50 nurses.

Table 2 provides the frequency counts and total scores from month one and month two for gender, age group, work shift, and experience for the nurses in the study. There were 45 females (90.0%) and five males (10.0%), whose ages ranged from 21-25 years (28.0%), 26-30 years (26.0%), 31-40 years (24.0%), and 41-60 years (22.0%) with a median age of 28 years. Twenty-six nurses worked the day shift (52.0%); twenty-four worked night shifts (48.0%). Thirty-four had 10 or fewer years of experience (68.0%) with 16 having more than ten years of experience (32.0%). Looking at the total scores, all categories of demographic variables were satisfied with bedside handover report process during month one and month two except for 5 males (10% of 50), who actually saw a decrease in scores from month one ($M = 4.54$, $SD = 0.55$) to month two ($M = 4.46$, $SD = 0.59$) as shown in Table 2.

Table 2

*Month One and Two Total Scores for Selected Demographic Variables*

| | | | | Month one | | Month two | |
|---|---|---|---|---|---|---|---|
| Variable | Category | *n* | % | *M* | *SD* | *M* | *SD* |
| Gender | | | | | | | |
| | Male | 5 | 10.0 | 4.54 | 0.55 | 4.46 | 0.59 |
| | Female | 45 | 90.0 | 4.06 | 0.71 | 4.30 | 0.61 |
| Age [1] | | | | | | | |
| | 21-25 | 14 | 28.0 | 4.28 | 0.49 | 4.49 | 0.59 |
| | 26-30 | 13 | 26.0 | 3.82 | 0.55 | 4.10 | 0.65 |
| | 31-40 | 12 | 24.0 | 3.99 | 0.93 | 4.08 | 0.59 |
| | Over 40 | 11 | 22.0 | 4.38 | 0.75 | 4.62 | 0.43 |
| Work shift | | | | | | | |
| | Day | 26 | 52.0 | 4.07 | 0.70 | 4.34 | 0.63 |
| | Night | 24 | 48.0 | 4.15 | 0.72 | 4.30 | 0.59 |
| Experience | | | | | | | |
| | 10 Years or Less | 34 | 68.0 | 4.11 | 0.71 | 4.35 | 0.56 |
| | Over 10 Years | 16 | 32.0 | 4.12 | 0.72 | 4.26 | 0.71 |

*Note*. $N = 50$. Ratings based on a five-point metric: 1 = *Strongly Disagree* to 5 = *Strongly Agree*. [1] *Median* = 28 years.

Table 3 provides the results of matched-pair *t* test comparisons for the seven statements and their total scores in month one and month two to answer the DNP project question. The DNP project question asked: Will a bedside handover report result in nurse satisfaction at one month and two months postimplementation? Table 3 displays the paired *t* test comparisons for the seven statements and their total scores between month one and month two in the study. Inspection of the table found three out of eight changes had significant increase in scores at $p < .05$. Specifically, these significant increases in scores were for the ratings of Statement 3, “Bedside handover report provides time for the incoming RN to verify patient’s health issues that need to be addressed at once (for

the incoming shift; *p* = .05),” Statement 7, “I am satisfied with the handover report process conducted at the patient’s bedside (*p* = .01),” and total score (*p* = .03).

Table 3

*Comparison of Statements One through Seven and Total from Month One to Month Two. Paired t Tests*

| Statement | Month | *M* | *SD* | *t* | *df* | *p* |
|---|---|---|---|---|---|---|
| 1. RNs provides up-to-date patient care information. | One<br>Two | 4.20<br>4.30 | 0.81<br>0.84 | 0.66 | 49 | .51 |
| 2. Helps RNs to prioritize patient care activities. | One<br>Two | 4.14<br>4.38 | 0.93<br>0.86 | 1.47 | 49 | .15 |
| 3. Provides time to verifies patient care issues. | One<br>Two | 4.08<br>4.36 | 0.92<br>0.83 | 2.00 | 49 | .05 |
| 4. Provides comprehensive communication process between RNs. | One<br>Two | 4.38<br>4.42 | 0.78<br>0.70 | 0.34 | 49 | .74 |
| 5. Ensures RNs accountability. | One<br>Two | 4.14<br>4.36 | 0.99<br>0.75 | 1.47 | 49 | .15 |
| 6. Minimizes delays in patient care delivery. | One<br>Two | 3.92<br>4.12 | 0.80<br>0.92 | 1.40 | 49 | .17 |
| 7. Satisfied with the bedside handover report process. | One<br>Two | 3.92<br>4.30 | 0.80<br>0.71 | 2.91 | 49 | .01 |
| Total | One<br>Two | 4.11<br>4.32 | 0.70<br>0.61 | 2.20 | 49 | .03 |

*Note*. *N* = 50. Ratings based on a five-point metric: 1 = *Strongly Disagree* to 5 = *Strongly Agree*.

**Discussion of Findings in the Context of Literature and Frameworks**

The theory of organizational change supports this DNP project. The process of implementation and results have shown that practice change needs the involvement of nursing personnel at all levels. Each nursing personnel, from top to bottom tier, had contributed to the success of the implementation of the bedside handover report process. The finding of this study is comparable with the findings of several studies that had shown that organizational readiness for change is a multilevel, multifaceted construct

where all members shared resolve to implement a change (change commitment) and shared belief in their collective capability to do so (change efficacy; Weiner, 2009; Arden, 1999; Shapiro, 2010; Radtke, 2013; Thomas & Donohue-Porter, 2012).

In contrast, a hospital in England had conducted a two-year study utilizing the theory of organizational change. The process of implementing change started from the staff nurses level. Initially, they were involved with the development of the standard of care of patient with dementia. However, their immediate supervisors failed to recognize their efforts, thus their initiatives did not materialize. As a result, from this point the staff nurses felt isolation from the organization and lost direction (Ardern, 1999). In this case, failure to empower the staff nurses resulted in low morale and decreased enthusiasm to actively participate in the process of adopting change and working together as a team. A "method of holding the power" inhibited the staff nurses to participate continuously in adopting the change necessary in improving the care in this clinical setting (Ardern, 1999).

The engagement of nursing leaders is crucial from the first stage of problem definition (awareness) that the handover process needs to be changed and updated. I was supported by the executive nursing leaders from the initial stage of searching for a best practice in handover reports. The executive nurse council had chosen the bedside handover report process as the best practice that staff nurses have to use during shift change.

The second stage of the theory of organization change is the initiation of action (adoption). The nurse manager of the orthopedic and spine units readily accepted the offer as the trial nursing unit of the bedside handover report project. I was invited to

speak to the unit practice council leader about the handover report process trial. I informed the unit practice council members a month prior to the training of the handover report process. The training for staff nurses was conducted one month prior to the implementation of the bedside handover report process. The training schedule was sent to the nurse manager of the trial unit a week before the training started. The nurse manager made it possible for the staff nurses to attend the classroom training by arranging the coverage for the staff nurses during training so as not jeopardize patient care. The training was completed a month prior to the implementation of the bedside handover report due to the collaborative efforts with the unit nurse managers.

The third stage of the theory is the implementation stage. I performed a formative evaluation and identified barriers that hindered the success of the project on the first and second week of its implementation. The identified barriers were the following: (a) patient assignments for RNs were not distributed on time, (b) hourly rounding was not performed fifteen to thirty minutes before the change of shift, and (c) there was difficulty navigating the EMR in obtaining patient information. The nurse manager, staff nurses, and I huddled daily to address the issues that hindered the possibility of the staff nurses to conduct the handover report process at the bedside on time. In solving the issues, the nurse manager distributed patient assignments one hour before the shift change. The RNs and patient care techs (PCTs) conducted hourly rounding fifteen to thirty minutes before the end of the shift. Thus, the staff nurses offered favorable insights of the bedside handover report process on the second month of its implementation.

The institutionalization of the identified change is the fourth stage of the organizational change theory. On the second month, the RNs showed more satisfaction

with their practice change. RNs as well as their clinical support such as nurse leaders and PCTs adjusted and conformed to bedside handover report process on the second month. The result of the two-month survey was shared with the following: (a) unit practice council of the trial unit, (b) EBP and research council, and (c) nurse practice council. The nurse executive council approved the bedside handover report process to be used in the facility based on the results of the nurses' satisfaction survey.

## Implications

### Implications for Practice/Actions

The changes in health care industry affect nursing practice. Health care is becoming complex and nursing practice has to face the challenge to provide safe and excellent care. Patients' length of stay is getting shorter and the need to establish a strong relationship between patients and nurses is essential to promote healing and recovery through communication and collaboration.

A handover report process done at the bedside promotes collaboration and prevents communication gaps between incoming and outgoing nurses. At the bedside, the incoming nurses are able to perform focus assessment of their patients paying attention to IV sites and intravenous fluids, surgical wound, dressing and drainage, verifications of medication pumps in the presence of the outgoing nurses and checking the completeness of nursing documentation. This process facilitates a smoother workflow and improves the communication between the incoming and outgoing nurses (Thomas & Donohue-Porter, 2012).

Staff nurses need a process that enables to build relationship with patients and families. Performing the shift change handoff at the bedside encourages and supports

patients and families to participate in their desired level of care decision making, building on their strengths to enhance control and independence (Anderson & Mangino, 2006). Bedside handoff report is essential in building trust and respect between patients and nurses. During bedside handover report, staff nurses have the opportunity to engage patient and families to identify their individual goals. Staff nurses are able to prioritize the plan of care based on their patient's needs that facilitate early discharge of patients as plan.

**Implications for Future Research**

One of the barriers that I identified during the implementation stage of the project was the difficulty of finding patient information using the EMR. This barrier contributed with the delay of the handover process. A proposal to integrate a "patient summary" section in the EMR system to assist staff nurses to find patient information during the initial phase of the handover report process is recommended.

Implications for future research may include examining the use of the "patient summary" in the EMR system and how it affects the process of the bedside handover report. Disseminating the results to the other health care settings within the institution may initiate the replication of the bedside handover report process study in areas such as rehabilitation units, perianesthesia care units, ambulatory, and outpatient clinics.

Further study is recommended to discover why 5 males satisfaction scores decreased on the second month. In addition, the inclusion of "peer review" concept during bedside handover process needs to be assessed for the sustainability of the handover practice change.

### Implications for Social Change

The results of this project impact the quality of care that RNs provide in a 24-hour period. Bedside handover report process provides the time for nurses to verify and address patient's health issue earlier. Bedside handover report process provides the opportunity for nurses to engage and collaborate with their patients at the beginning of the shift. Establishing rapport and engaging patients at the beginning of the shift, RNs are promoting positive social change through patient education thus preventing complications after hospitalization. Furthermore, the result of this project impacts the quality of patient care in this facility. Bedside handover report improves nurse satisfaction that is essential for a positive social change not only for the nursing profession but also for patients' quality of life.

## Project Strengths and Limitations

### Strengths

The strength of this project was to promote the use of bedside handover report to establish better relationships between nurses and their patients. The health care delivery use by the facility is the RBC model. In RBC model, the caregiver consistently maintains the patient as the central focus of their care (Felgen, 2013). Conducting the handover report process at the bedside helps to build better relationships between nurses and patients and families in a short period of time by direct communication. It is in these relationships that patients and families receive support and guidance necessary for them to recover and heal (Campbell, 2004).

**Limitations**

One of the limitations of this project includes the use of small convenience sample (*n* = 50) in the orthopedic and spine units of the facility. This sample may not represent the findings that are applicable for other services of the facility such as, rehabilitation, neurology, pediatrics, and critical care units.

Other limitation includes the length of time between the project implementation and data collection. The bedside handover report process was a change in behavior and practice for quite number of staff nurses. Discussing patient care issues at the bedside in semi-private rooms is one of the fears that hindered staff nurses to practice the handover report process fluently due to the fear of violating patient confidentiality when patient's information is discuss at the bedside with the presence of the (other) patient and family in the same room.

**Recommendations for Remediation of Limitations**

The nursing leaders approved the bedside handover report process in the facility. It is an evidence-based handover report practice that promotes quality and safe patient care as reported by several studies conducted by several health care facilities and organizations. Another study needs to be conducted by using different samples who may represent the group of staff nurses working in the facility.

The length of time between practice change implementation and data collection needs to be considered as well. Time is of the essence in implementing change in nursing practice. Changing practice can be a daunting task that involves a realization that a change is required and acceptance that it can bring improvement (Radtke, 2013).

A longitudinal study of six months to a year is needed to address and resolve operational nursing issues and technology issues that served as obstacles for the staff nurses to be satisfied with the bedside handover report process. Several nursing researchers used in this project had conducted their studies after three months to a year of implementing bedside handover report process to their facilities. Providing nurses the element of time and resources to understand the principle behind bedside handover report process may provide the opportunity for the practice change to be sustained and successful.

## Analysis of Self

### Scholar

Tolk (2012) conducted a survey about the characteristics of a scholar. Based on this study, a scholar must have, (a) a vision to pursue and conduct research for self-improvement and for others, (b) an insight about advancing the field of study to improve practice, (c) an open mind to understand a range of views and be receptive to ideas of other researchers, (d) tenacity with the ability to continue in the face of set backs, delays, criticism, and rejection, (e) ethics rooted in honesty about own work and treating others with respect, and (f) mentoring skills to coach and introduce others to the field of expertise they represents.

This rigorous journey provided the student the opportunity to understand the duty and responsibility of obtaining a doctoral degree in nursing. At the end of the program, the student must continue to have a vision and insight to promote the use of nursing research and EBP to improve nursing practice and patient care. The student must possess ethics and an open mind in integrating, analyzing, and critically appraise nursing

research. The student learned about tenacity and patiently works with diligence to produce scholarly materials. Lastly, the student will continue mentoring others about nursing research process and use of EBP in nursing.

**Practitioner**

This student practice specialty is nursing education and professional staff development. American Nurses' Association (2016) identified the six roles of nurse educator as follow, (a) administrative, (b) educator, (c) researcher, (d) mentor, (e) facilitator, and (f) consultant. As a nurse educator, this program provided the student the knowledge and concrete foundation to continue to carry out the roles to improve nursing practice. The knowledge and skills learned from this program is valuable for the student to, (a) educate staff nurses about nursing research and EBP, (b) conduct research, (c) facilitate nursing research activities, (d) mentor staff nurses to identify issues and encourage use of EBP, and (e) provide consultation to peers about nursing research and its use in promoting a safe environment for staff nurses and patients.

**Project Developer**

As a project developer, the student was able to identify, develop, and implement the bedside handover report process in the acute care services of the facility. The Bedside Handover report project development experiences include, (a) identification of handover report process issues, (b) searched for best practice, (c) developed a curriculum for nurses' skills training, (d) presentation of the project to Research and EBP Council, (e) IRB application for approval of the study, (f) implementation of the project, (g) data collection, (h) data analysis, and (i) evaluation of the project affecting staff nurses' satisfaction with regards to the practice change. The student is eager to share the results

with the facility's chief nursing officer, pilot nursing units, and nursing councils. Based on the results of the project, the student will be proposing to implement bedside handover report process to other health services and settings throughout the facility.

## Summary and Conclusions

Due to the complexity of health care delivery, staff nurses must be attuned with the changes that it brings and face it with adversity. Nursing research and EBPs are available to improve nursing practice. Staff nurses need the support of the organization to adopt best practice that promotes a culture of safety. Bedside handover report provides a safe environment for both nurses and patients. Staff nurses preferred an environment that is safe and protect nursing practice. The positive response of the staff nurses from the pilot unit served as a guide for further project implementation in the facility. Since the pilot was small, another data collection is recommended when the project will be implemented in the entire facility.

Adopting bedside handover report process is meeting the standard and goal of the Joint Commission. The Joint Commission advocates for health care facilities to create organization cultures of safety and quality that value patient-centered communications as an integral component of delivering patient-centered care (Reinbeck, 2013).

## Section 5: Scholarly Product

The student submitted an abstract for the New York State Simulation (NYSIM) Symposium on October, 2015. See Appendix F for acceptance from the NYSIM Symposium and research committee and Appendix G for a copy of the 3’ x 5’ poster.

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Appendix A: Literature Summary with Level of Evidence

| Reference | Research Method | Main Findings | Level of Evidence |
|---|---|---|---|
| Staggers, N. & Blaz, J. W. (2012). Research on handoffs for medical and surgical settings: An integrative review. *Journal of Advanced Nursing.* 247-262. | Integrative review of the literature with a purpose of synthesizing outcomes on handoffs to guide future processes on medical and surgical units. | The authors had concluded that bedside handover report process could be delivered in any format as long as it is design to provide safe and quality care, prevent error in communication, and promote staff satisfaction with its use. | Level IV |
| Street, M., Eustace, P., Livingston, P. M., Craike, M. K., Kent, B., & Patterson, D. (2011). Communication at the bedside to enhance patient care: A survey of nurses' experience and perspective of handover. *International Journal of Nursing Practice*, *17*, 133-140. doi:10.111/j.1440-172X.2011.01918.x | Cohort studies of nurses' experience and perspective of handover communication at the bedside to enhance patient care in Australian public hospitals. | Preliminary findings stated that improvement in practice was noted after the implementation of the process and required a long-term evaluation to prove its success. | Level VI |
| Evans, D., Grunawalt, J., McClish, D., Wood, W., & Friese, C. R. (2012). Bedside shift-to-shift nursing report: Implementation and outcomes. *MedSurg Nursing*, *21*(5), 281-292. | Randomized controlled trials of implementation and outcomes of bedside shift-to-shift nursing report with the purpose to solve the issue of staff dissatisfaction with nurse-to-nurse report and inability to complete the shift at the scheduled time. | Findings of the study suggested that bedside handover report increased nurse satisfaction, helped nurses to prioritize their workflow better, and decreased amount of time for report. | Level V |

| Reference | Research Method | Main Findings | Level of Evidence |
|---|---|---|---|
| Maxson, P. M., Derby, K. M., Wrobleski, D. M., & Foss, D. M. (2012). Bedside nurse-to-nurse handoff promotes patient safety. *MedSurg Nursing*, *21*(3), 140-144. | A randomized-controlled trial relating to bedside handover report process in promoting patient safety. The purpose of the study was to determine if bedside nurse-to-nurse handoff increases staff satisfaction with communication and accountability and increases patient satisfaction with the plan of care and increases patient perception of teamwork. | Findings of the study concluded that patient's participation in change-of-shift discussions with the nurses has the potential to decrease medication errors, enhance and increase communication among health care team members, patient/family that promotes and encourages an environment that emphasizes patient safety and quality. | Level V |
| Sand-Jecklin, K., & Sherman, J. (2013). Incorporating bedside report into nursing handoff: An evaluation of change in practice. *Journal of Nursing Care Quality*, *28*(2), 186-194. | Quasi-experimental design to evaluate the implementation of bedside reporting, process, and outcomes in terms of effectiveness, efficiency, patient and staff satisfaction, and impact on patient safety. | The findings resulted to an improved nurses' perception on accountability and patient involvement in care. The study had reported that medication errors (a 50% reduction rate) patient falls at shift change (a 35% reduction rate). | Level IV |

| Reference | Research Method | Main Findings | Level of Evidence |
| --- | --- | --- | --- |
| Thomas, L., & Donohue Porter, P. (2012). Blending evidence and innovation: Improving intershift handoffs in a multihospital setting. *Journal of Nursing Care Quality*, *27*(2), 116-124. | Cohort study with the purpose of standardizing nursing practice across the hospital systems aligning with the Joint Commission requirements of minimizing the risk of error related to ineffective communication during shift change. | The findings of the study concluded that bedside handover report process had a profound significance for nursing, not only on its potential impact on patient safety but also in its investigation of patient satisfaction outcomes, communication, collaboration, team work, and promotion of patient-centered care. | Level VI |
| Nelson, B. A., & Massey, R. (2010). Implementing an electronic change-of-shift report using transforming care at the bedside processes and methods. *The Journal of Nursing Administration*, *40*(4), 162-168. | Randomized controlled trial with a purpose of developing, testing, and implementing an electronic template and process for the change-of-shift report associated with Transforming Care at the Bedside (TCAB) model. | The findings of the study reported that using the TCAB model increased staff satisfaction associated with leaving on time, report process was efficient, and patient information were useful and updated. | Level V |
| Matic, J., Davidson, P.M., & Salamonson, Y. (2010). Review: Bringing patient safety to the forefront through structured computerization during clinical handover. *Journal of Clinical Nursing, 20,* 184-189. | An integrative review with the purpose of examining different methods of handover delivery and usability of electronic handover system in healthcare settings. | The authors concluded that clinical handover has to undergo increased scrutiny, development, and research. | Level IV |

| Reference | Research Method | Main Findings | Level of Evidence |
|---|---|---|---|
| Riesenberg, L. A., Leitzsch, J., & Cunningham, J. M. (2010). Nursing handoffs: A systematic review of the literature. *American Journal of Nursing*, *110*(4), 24-34. | A systematic review with the purpose of identifying barriers and strategies for effective handoffs. | Based on this systematic review, the researchers found out that very little research has been done to identify best practice on nursinghandoffs. | Level II |
| Johnson, M., Jefferies, D., & Nicholls, D. (2011). Developing a minimum data set for electronic nursing handover. *Journal of Clinical Nursing*, *21*, 331-343. doi:10.1111/j.13652702.2011.03891.x | Randomized trial with the use of an electronic system to complement verbal nursing handover. | The findings concluded that nurses preferred the use of Nursing Handover Minimum Data set items to facilitate the process of handover. | Level V |
| Radtke, K. (2013). Improving patient satisfaction with nursing communication using bedside shift report. *Clinical Nurse Specialist,* 19-25. doi:10.1097/NUR.Ob013e31827777011 | Randomized trial about improving patient satisfaction with nursing communication using bedside shift report. | Findings of the study concluded that bedside shift report could improve handover communication to improve patient safety, an approach to patient care that can enhance patient satisfaction through communication. | Level V |

Appendix B: NYU Hospital for Joint Diseases Bedside Handover Report Staff Nurses' Satisfaction Survey

Directions:

Please complete this survey to let us know your feedback regarding the RN to RN Bedside Handover Report Process. Use the following rating scale to rate each survey item: **Strongly Agree** = **5** **Agree** = **4** **Neutral** = **3** **Disagree** = **2** **Strongly Disagree** = **1. Feel free to provide comments in the spaces provided.**

1) During bedside handover report, the outgoing RN provides up-to-date patient care information to the incoming RN at shift change (medication administration, discharge planning information, consultation/referral, PT/OT schedules, procedures, treatments, etc.)

1- Strongly Disagree 2 -Disagree 3- Neutral 4 - Agree 5- Strongly Agree

2) Bedside handover report process helps RNs to prioritize patient care activities for it facilitates "real time" focus assessment of patient's status/condition.

1- Strongly Disagree 2 -Disagree 3- Neutral 4 - Agree 5- Strongly Agree

3) Bedside handover report process provides time for the incoming RN to verify patient's health issues that needs to be addressed at once (for the incoming shift).

1- Strongly Disagree 2 -Disagree 3- Neutral 4 - Agree 5- Strongly Agree

4) Bedside handover report provides a comprehensive communication process between outgoing and incoming RNs thus results to safer patient care delivery.

1- Strongly Disagree 2 -Disagree 3- Neutral 4 - Agree 5- Strongly Agree

5) Bedside handover report process ensures RN's accountability by providing comprehensive report that matches patient's condition/status.

1- Strongly Disagree 2 -Disagree 3- Neutral 4 - Agree 5- Strongly Agree

6) Bedside handover report process minimizes delays in providing patient care delivery.

1- Strongly Disagree 2 -Disagree 3- Neutral 4 - Agree 5- Strongly Agree

7) I am satisfied with the handover report process conducted at the patient's bedside.

1- Strongly Disagree 2 -Disagree 3- Neutral 4 - Agree 5- Strongly Agree

**Demographic:**

**Gender:** Female [ ] Male [ ]

**Age:** 21-25 yrs old [ ] 26-30 yrs old [ ] 31-35 yrs old [ ]

36-40 yrs old [ ] 41-45 yrs old [ ] 46-50 yrs old [ ]

51-55 yrs old [ ] 56-60 yrs old [ ] 61-65 yrs old [ ]

**Work Shift:** Day Shift [ ] Evening Shift [ ] Night Shift [ ]

**Years of Nursing Experience:**

1-10 yrs [ ] 11-20 yrs [ ] 21-30 yrs [ ] 31-40 yrs [ ]

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**Comments/Suggestions:**

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# Appendix C: Bedside Handover Report PowerPoint Presentation (Lecture and Discussion)

10/5/2016

Bedside Handover Report

Advantages of Bedside Handover Report

Bedside Handover Report: FOCUS Assessment Approach

Why Bedside Handover Report?

Professional Development Training

References

Desired Outcomes of Bedside Handover Report

Review of Pt's. Record: DATA Format

1

# Appendix D: DATA Format

NYU Hospital for Joint Diseases
Department of Nursing
Division of Nursing Education/Staff Development
Bedside Handover Report
**DATA Format**

| I.D-emographics | II. A-ssessment |
|---|---|
| • Patient's name<br>• Age<br>• History- medical/surgical<br>• Allergy<br>• Code status<br>• Advance directives(check the record)<br>• Language spoken<br>• Surgical procedure done | • Current Vital signs<br>• Rhythm/Telemetry information (if applicable)<br>• Skin assessment<br>• Surgical wound dressings<br>• IV site; IV fluids (open I&O); urine output; BM (if applicable)<br>• Any drains? Hemovac, JP, foley cath, chest tube(if applicable)<br>• Presence of any devices: AVI, SCD, CPM (if applicable)<br>• Review MAR; PCA (must be verified at the bedside)<br>• NV status assessment<br>• Lab reports (mention only when there is an abnormality)<br>• Radiology (if applicable); Accuchek (if applicable)<br>• Safety Alerts/Special precautions (Falls, Suicide, Restraints) |
| **III. T-reatment** | **IV. A-action (to be acted upon for the next 12 hours)** |
| • Care plan review<br>• Patient Education review<br>-any teachings to be done for patient, family, and/or significant others, i.e. Lovenox injection, use of cryotherapy at home, On Q Pump, etc. | • Any procedure patient is going to have; if any, ticket to ride filled-up? Consent signed?(if applicable)<br>• Any medication due; What time the last pain medication given?<br>• Is the patient to be discharged? Prescription/instructions given to patient; Medication reconciliation completed (if applicable); Family members aware?<br>• Follow-up lab works? (if applicable)<br>• Patient's concerns that needs to be addressed |

***Note: Provide pertinent information to the incoming nurse "if applicable"only.**

## Appendix E: Bedside Handover Report Script

| **I. 15-30 minutes prior to Bedside Handover** |
|---|
| Outgoing RN rounds on all patients and addresses:<br>• Pain<br>• Positioning<br>• Personal needs<br>• Possessions<br>• Presence<br>Introduces/reinforces process of bedside handoff<br>Asks who should be included (family/visitors) in report |
| Incoming RN reviews medical record in EMR:<br>Overview with signout/worklist/MAR/Patient handoff report:<br>• Pertinent Past and current patient history/procedures and outcomes of interventions to date<br>• Allergies<br>• Special precautions (ie: falls/isolation/1:1 observation/difficult airway/precautions for taking BP)<br>• Language spoken<br>• Code status/advanced directives<br>• Vital signs/pain score<br>• Care Plan/Patient education<br>• Discharge Plan/Patient preferences<br>• LIP orders (medications/diagnostics/LDA/I&O/diet) |
| **II. Handover report at the patient's bedside** |
| a. Introduces oncoming nurse to patient and family and "manages up" the oncoming nurse |
| b. Oncoming nurse validates patient identity using armband and updates information on the patient care board |
| c. Reviews plan of care with patient and encourages patient/family to participate:<br>• Pain<br>• Ambulation<br>• Tests/Procedures<br>• Plan of care/discharge or transfer plan |
| d. Conducts a focused assessment of the patient<br>• Pain/interventions for comfort/positioning<br>• IV sites/ IV infusions/medicated drips<br>• Wounds/incisions/drains/catheters<br>e. Environmental safety assessment<br>• Call bell in reach/bed alarms/emergency equipment/clutter free environment |
| **III. Prior to leaving bedside** |
| • Addresses questions from patient/family |
| • Asks: "Is there anything else we can do for you?" |

**Adopted from NYU Medical Center Bedside Handover Report Competency Checklist*

# Appendix F: Scholarly Product

**Principe, Imelda**

| | |
|---|---|
| **From:** | Ng, Grace |
| **Sent:** | Friday, October 02, 2015 5:32 PM |
| **To:** | Principe, Imelda |
| **Cc:** | Sulzona, Pedro |
| **Subject:** | RE: Abstract, re. poster presentation: Bedside Handover Report Process |

Hi Imelda, below are my comments:
I am very pleased to inform you that your poster abstract **Bedside Handover Report** has been **ACCEPTED** for presentation at **Hot Topics in Simulation Education**. Please notify your co-authors. We look forward to including it in the poster session. **Please RVSP to this email to confirm your participation at your earliest convenience.**

I reviewed your poster. Here are my brief comments based on our evaluation rubric, as well as instructions for presenting your poster.

**Reviewer Comments**: Thank you for the opportunity to review this abstract. This abstract is very clearly written and a pleasure to read. The background and rationale for the program innovation is well delineated.

**Instructions:**

Display: The posters will be displayed on walls. We will provide materials to attach your poster to the walls.

Poster Size: Your poster should be 3'x5'

Location & Set-up time: We will contact you prior to the symposium to inform you of the location and set-up time for your poster.

Please contact Pedro Sulzona pedro.sulzona@nyumc.org or myself if you have any questions or concerns.

Thank you, and looking forward to seeing you in October!

# Appendix G: Poster Presentation