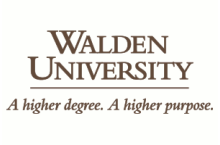


2020

Effectiveness of End of Shift Bedside Report

Glory Abuajah
Walden University

Walden University

College of Nursing

This is to certify that the doctoral study by

Glory Abuajah

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Robert McWhirt, Committee Chairperson, Nursing Faculty
Dr. Joan Hahn, Committee Member, Nursing Faculty
Dr. Diane Whitehead, University Reviewer, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2020

Abstract

Effectiveness of End-of-Shift Bedside Report

by

Glory Abuajah

MS, Walden University, 2016

BS, University of Phoenix, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2020

Abstract

Nursing shift reports are the primary communication mechanism for outgoing nurses to transfer information about a patient to oncoming nurses. Nurse shift reports and nurse handovers are two of the most critical patient care processes that can support patient safety and reduce medical errors. But many nurses do not recognize the evidence supporting the practice of bedside reporting (BSR). In response to this practice problem, this project involved education on the importance of BSR on a telemetry unit in line with the best available evidence. The goal of the staff education project was to educate the staff on the value of BSR processes in delivering patient care. The project question addressed whether continuing education on the importance of BSR would enhance nurse's awareness of the evidence to support compliance with BSR. The project was guided by the theory of Malcolm Knowles promoting the fundamentals of evidence-based research and positive patient outcomes in the profession. An educational intervention on BSR was provided to a sample of 15 nurses on a 26-bed telemetry unit. The sample scored an average of 39.0 on the pretest and 47.27 points on the posttest. There was 8.27-point increase, which was statistically significant (p = 001). This project promotes social change by improving nurses' knowledge of the impact of a bed shift reporting system on patient safety, communication improvement, quality of care, and patient involvement for different types of handoff practices within various care units and organizational settings. An anticipated outcome of this project is the improvement in the quality of care and safety of patients by integrating them into a culture of safety at all levels of health care.

Effectiveness of End-of-Shift Bedside Report

by

Glory Abuajah

MS, Walden University, 2016

BS, University of Phoenix, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2020

Dedication

This project is dedicated to the memory of my beloved late father chief John Odinankeonye Okeh (Omemgbeoji 1 of Usaka Ukwu Kingdom) and also to my loving mother Lolo/Mrs. Grace Okeh Ezinne Ugoagu and to my ever supportive family whose trust and believe in me helped me survive graduate school.

Acknowledgments

I wish to thank the almighty God for His grace and loving kindness towards me. My acknowledgement goes to my wonderful and supportive husband Prince George Abuajah and my children Carolyn Abuajah, Nelson Abuajah, Kimberly Abuajah, and Terrence Obinna Abuajah., my mother Lolo Grace Ezinne Okeh, and my brothers and sisters: Dr. Godwin Okeh, Rita Okeh, Godfrey Okeh, and Mrs. Ngozi Nwoko. I wish also to acknowledge my project committee members, Dr. Robert McWhirt, Dr. Joan Hahn, and Dr. Diane Whitehead, whose constructive criticism brought this project to completion. I also don't want to forget to thank my pastor Bishop Dr. George Creppy for all the prayers and spiritual support.

.

Table of Contents

List of Tables

List of Figures

Section 1: Nature of the Project

Introduction

End-of-the-shift bedside reports (BSRs) are a method for incoming nurses to receive a critical information from outgoing nurses at a patient's bedside. A nurse performing the end-of-shift report at a patient's bedside also allows a patient and their family members to participate and ask questions. The practice of BSRs increases patient satisfaction, promotes patient safety, and gives the patient the opportunity to become more involved in their care (Sand-Jacklin & Sherman, 2014). In Section 1, I discuss the problem statement and purpose of the project.

Problem Statement

This project was developed to improve the change of shift report process on the unit. Three years ago, a small rural hospital in the southeast United States implemented a new policy mandating all nursing staff to conduct their end-of-shift reports at patients' bedside, enabling patient and family member to participate in the report. However, most nurses continued to conduct their end-of-shift report at the nurses' station rather than bedside. When the report is created away from bedside, the opportunity to visualize the patient and include the patient and family in the exchange of information and care planning is lost. When the report process is taken to the bedside, patients and families, as agents in patient safety, are given an opportunity to hear and participate in the exchange of information. But this also may be a new and challenging process for nursing staff. Though bedside report models integrating the patient into the triad have been shown to enhance patient involvement and strengthen support and education for caregivers

(Alvarez, 2019), many nurses fail to recognize the evidence supporting the practice of BSRs (Gregory, Tan, Tilrico, Edwardson, & Gamm, 2014). Creating awareness of the importance of BSRs will impact patient satisfaction and outcomes and has the potential to reduce overtime costs and budget shortfalls (Sarvestani, Jafari, & Moattari, 2018). Implementing a BSR policy in facilities still reporting on patients in the hallway or at the nursing station will benefit patients. Compliance with these standards has been shown to reduce costs for healthcare facilities and increase patient satisfaction (Sarvestani, Jafari, & Moattari, 2018). Among the benefits are less overtime costs leading to budget overages, lower legal costs related to falls and medication errors, and enhanced patient experience surveys scores from the Hospital Consumer Assessment of Healthcare Providers and Systems (Ofori-Atta, Binienda, & Chalupka, 2015).

This Doctor of Nursing Practice (DNP) project is a staff education program on BSR with the goal of increasing participation with this modality. The delivery of safe, high-quality care depends on accurate and timely communication among nurses as well as the involvement of the patient and/or the patient's family. BSR has the potential to decrease patient and family anxiety, including the feeling of abandonment that can occur at nursing shift changes. In the current healthcare system, patients likely encounter a few providers, which can lead to a higher number of handoffs. With each handoff, the probability of experiencing lost or missing information increases (Cairns, Dudiak, Hoffmann, & Lorenz, 2013). Using a standardized format of handoff communication significantly reduces the risk of miscommunication (Brouwer, & McClaskey, 2019). For

instance, The Joint Commission (2007) reported that approximately 70% of sentinel events and medical errors are caused by ineffective communication.

Purpose Statement

Ineffective communication during shift-to-shift reporting represents a safety challenge for nursing leaders. Approximately 80% of serious medical errors transpire during nurse handoffs (Manges & Groves, 2019). Nursing shift reports are the primary communication mechanism for outgoing nurses to transfer information about a patient to oncoming nurses. Barriers to implementing BSR include the fear of violating patient privacy and confidentiality, a concern that interacting with the patient increases report length, uncertainty of what to say in front of the patient, worry that medical jargon will increase patient anxiety, and resistance due to discomfort with the new process. The purpose of this project is to increase nurses' knowledge and skills in using the BSR to improve compliance with the existing policy. This project provided supportive education to reinforce the policy and the overall need for BSR. The practice question was "Will a staff education program on end-of-shift BSRs increase staff perception of their knowledge and commitment to conducting daily end-of-shift reports at patients' bedsides?" The importance of this project is that it will assist nurses in following though as using this BSR will save patient lives.

Nature of the Doctoral Project

This project was conducted at the 26-bed telemetry care unit of a nonprofit urban hospital in the southeast United States. This unit is staffed by registered nurses (RNs) and certified nursing assistants (CNAs) along with a unit RN charge nurse. A nurse

practitioner hospitalist is also available on the unit. For each shift, staffing includes four to five RNs and four to five CNAs.

The purpose of the project was to inform nurses the importance conducting end-of-shift report at the bedside through use of a staff education program. The program consisted of an educational learning activity and a pre posttest was used to evaluate the effectiveness of the activity. The approach was developing an education program (e.g., handout), which is vetted based on clinical stakeholders and experts. All RNs and CNAs were invited to participate in the education program. The program was offered several times to ensure availability to all shifts. Evidence for this project was based on a search of the literature, evaluation provided by the expert panel during education development, and data to assess staff knowledge gained using the pre- and post-test.

Significance

Effective end-of-shift BSRs can improve communication among the frontline staff. BSR decreases incidents and adverse events such as falls and pressure ulcers (Evans et al., 2012). An average cost for a patient falls injury is approximately $35,000 (Centers for Disease Control and Prevention, 2015). If the BSR prevents even one fall, that could be a savings of approximately $32,653. Likewise, the cost of individual patient care with pressure ulcers ranges from $20,900 to $151,700 per pressure ulcer (Agency for Healthcare Research and Quality, 2014). BSR is more efficient than a report given at the nurse's station or a recorded report because it can take less time, leading to lower costs (Halm, 2012). The outgoing nurse is more apt to end their shift on time, preventing

accidental accumulation of overtime and allowing the incoming nurse to begin her shift on time (Evans et al., 2012).

The results of this project have potential to benefit the staff, the hospital system, and the patients when project results are shared. The positive social change that this project may lead to is improving patient care and quality outcomes (Mohammed & Elhadi, 2019). Other benefits of BSR are diverse, including increased patient engagement and understanding of treatment, decreased patient and family anxiety, decreased "departure" feelings during shift changes, increased nurse transparency, increased teamwork and nursing relationships, and decreased potential. (Mohammed & Elhadi, 2019)

Summary

End-of-shift BSRs are a way to communicate important unit values such as prioritizing patient safety and developing strong nurse–patient relationships and teamwork between nursing shifts. Being at the bedside and reviewing the chart allows outgoing nurses to feel closure and incoming nurses to feel well prepared (Manges, & Groves, 2019). In Section 1, I introduced the gap in practice and the practice question: Will a staff education program on end-of-shift BSRs increase staff perceptions of their knowledge and commitment to conducting daily end-of-shift reports at patients' bedsides? In Section 2, I describe the evidence supporting this project, Malcolm Knowles' theory of adult learning that frames the project, the local background and context, and my role in planning, implementing, and developing this education project.

Section 2: Background and Context

Introduction

Medical errors are a public health issue and leading cause of death in the United States (Rodziewicz & Hipskind, 2019). Part of the solution is to create a culture for identifying security challenges and adopting viable solutions rather than a system of blame and retribution. Healthcare organizations need to cultivate a safety culture that focuses on improving the system by treating medical errors as problems that need to be addressed. BSRs are an opportunity to reduce errors and interaction and cooperation between nurses. It has been shown that BSR models integrating the patient into the triad enhance patient satisfaction and strengthen support and training for caregivers (Amer, 2019). Though nurse shift reports and nurse deliveries are two of the most critical patient care processes that support patient safety and decrease medical error, nurses have not fully recognized the evidence supporting this procedure (Schirm, Banz, Swartz, & Richmond, 2018). The practice focus question was “Will a staff education program on the end-of-shift BSR increase staff perception of their knowledge and commitment to conducting daily end-of-shift bedside reports?”

Concepts, Models, and Theories

Malcolm Knowles’s theory of adult learning was used to frame this project. The theory of adult learning, which Knowles developed in the early 1970s (Knowles, 1973), is based on five axioms about how adults learn. Knowles stressed that adults are self-directed and have decision-making accountability. Adult learning services should,

therefore, take this fundamental aspect into account. When adults are self-directed, they should have a say in their learning material and process.

Knowles also mentioned four learning theories one of which is cognitivism. Cognitivism relies on the philosophy of conscious thinking, communication, judgment calls-, and emotion and focuses on the mental processes necessary for cognitive development (Rattray, el al, 2019). The theory is that individuals understand learning as they search for new information and match it with prior knowledge, they will be more likely to find meaning and continuity (Tennant, 2019). Like behaviorism, cognitivism is common in the digital age because many people take up online learning to delve deeper into an experience they have learned through conventional lessons. Students of this theory can then combine their new experience in digital learning with the knowledge and skills they already possess.

The second theory Knowles (1973) discussed is constructivism, which highlights the importance of social influences, free will, and individual cognition. The tenet that individuals exist in a rapidly and continually changing world that hangs on experience is central to constructivism (Tennant, 2019). The social element in the classroom is important for many people who work in education, where fellow educators share theories and ideas with one another and expand on them.

The third theory is connectivism, which is a newer educational approach that is premised on giving students more flexibility in the way they choose to learn (Purwanti, 2017). In terms of course work and how it is evaluated, there is more transparency today, and students and tutors use the advantages of this interactivity to provide input along the

way. The primary role of teachers adopting connectivism is to create the learning environment and then let collaborative effort develop naturally between students, much like a constructivist (Purwanti, 2017). This is what happens when educators create an entirely new learning environment for modules and courses online.

The fourth and the last theory mentioned by Knowles is behaviorism, which revolves around concrete, predetermined goals (Purwanti, 2017). It is also the basis for many of the most common learning forms among parents and teachers and is especially useful when it comes to rote fact-learning (Purwanti, 2017). Although education has dramatically changed with technology consumerization, this form of learning is still useful when taking an online course. The periodically calculated goals involved in behaviorist approaches to education are important for managing time and successfully completing a course. Table 1 aligns this theory (French, 2019) with the education program.

Table 1

Alignment of Adult Learning Theory with the Education Program

Principles of Adult Learning	Application to Project
Adults move from dependency to increasing self-directedness in their learning	Educating staff members on the importance of end-of-shift bedside report will help them to be self-directed in completing this task
Adults draw on an accumulated reservoir of life experiences to aid learning.	Because adult learns better with life experience, I will provide literature review on the error that is as a result of miscommunication during shift reports. We will discuss experiences they have had with missed care due to a poor shift report
Adults are ready to learn when assuming new social or life roles	I will direct and encourage all RNs, CNAs and unit charge nurses to participate during shift report
Adult learning s problem centered. Adults want to apply new learning immediately	I will present the advantages of performing end-of-shift reports at patient bedside which include increasing patient satisfaction, promotes patient safety, and gives patient the opportunity to become more involved in their care.
Adults are motivated to learn by internal, rather than external, factors.	I will support and encourage participation throughout the whole process. These caring professions are motivated by wanting to do the best for their patients. Knowledge of the importance of the BSR should motivate them to be responsible for doing the best care.

Note. Information on theory from Harper and Ross (2011).

Relevance to Nursing Practice

The preparation of the end-of-the-shift statement is one of the essential duties of the nurse. The nurse is responsible for providing the patient with a concise report on their care over the past 12 hours. Hospital leaders have used several tactics to allow nurses to report and receive these statements. Some of them are by phone, tape recording, computer software, verbal communication outside of the room, and verbal communication at the bedside (Waters, 2019). But even after multiple attempts to structure reporting tools, educate, coach, and mentor, there are still nurses who do not see the benefit of bedside patient handoff (Foster, Abraham, & Gillum, 2019). To gain buy-

in, nursing leaders need to answer the following important questions: Do nurses see the importance of hand-off bedside patients?, do they think it is a problem for health and/or quality?, and do they understand and/or accept that delivery of care is a patient-centered approach? Nurses must be aware of the significance and potential outcomes of refusing to employ patients at their bedside (Waters, 2019). Highlighting patient safety and the procedures that produce positive results is crucial for healthcare institutions to remain viable in today's healthcare environment. Additionally, patient satisfaction is an important part of the financial viability of healthcare organizations (Kullberg, Sharp, Johansson, Brandberg, & Bergenmar, 2019).

Communication

Miscommunication, which can occur during communication with handoff (Kannampallil, 2018; Reese et al., 2018), results in medical errors (Khan et al., 2017). Due to lack of critical information, confusion of critical information, or delay in care, miscommunication between departments during patient handoffs can lead to errors in treatment. In the environment of long-term care, inadequate communication and poor coordination have been shown to contribute factors to 89% of adverse events, such as drug mistakes, delayed or improper treatments and missing nursing care (Andersson et al,2018). Ineffective communication remains a major factor contributing to health care accidents and sentinel events leading to deaths and costing billions in malpractice (Rucker & Windermuth, 2019; Summer et al., 2019). But using reliable interaction standards during treatment transitions enhances patient safety and safety culture (Patel & Landrigan, 2019). End-of-shift BSR is about who knows the patient best, sharing

information, and learning to trust and respect each other. It is about working together toward a mutual goal of providing our patients with the best and safest care possible. Without patient and family involvement in the transfer, nurses can make many hypotheses about what is best for the most personal needs of their patients (Bourgault, 2019). To maintain patient safety, nurses have a leading role in sharing important patient information. Errors associated with communication failures can be avoided by discovering at which stage of the process and between which staff such communication deficiencies occur to find solutions to prevent recurrence of these errors.

I utilized Malcolm Knowles's theory to educate nurses on the importance of communicating effectively during end-of-shift BSR. I provided staff members with the literature that shows the errors as a result of ineffective communication during end-of-shift report. The way treatment is provided impacts contact between health care providers and patients; it is just as critical as the treatment. The outcomes of successful interpersonal healthcare communication lead to improved patient satisfaction and positive improvements in healthcare (Rucker, Rucker, & Windermuth, 2019). The National Association of Emergency Medical Services Physicians highlighted the importance of high-quality contact between emergency medical services and personnel in the emergency department to provide healthy, efficient treatment. For example, in critically ill pediatric patients, the quality of transition coordination from emergency medical services to emergency department teams requires more exploration. During change handoff, valuable information is often lost. Using the Malcolm theory program with nurses to teach techniques for teamwork improvement and communication strategies

along with the use of validated handoff methods will help improve communication during shift handoff (Rucker at el., 2019).

Fucik (2019) did a study and found out that insufficient hand-off coordination is a factor in many adverse events, including many forms of sentinel incidents. According to the sentinel event database of the Joint Commission, inadequate hand-off communication was responsible for adverse events, including surgery on the wrong site, delay in treatment, falling, and medication errors (Joint Commission, 2017). A 2016 study estimated that communication problems in U.S. hospitals and medical facilities accounted for at least part of 30% of all allegations of malpractice, resulting in 1744 deaths and $1.7 billion in the cost of malpractice over five years (The Joint Commission, 2017). BSR handoff improved communication and increased participation of the patient and family. BSR also decreased the rate of decline, helped build better relationships between patients, families, and health workers, and saved patient care time (Fitzpatrick & Small, 2017).

End-of-Shift Report

Handoff is considered a high-risk period in the emergency department for medical errors to occur (Campbell & Dontje, 2019). A quality enhancement plan was initiated in response to concerns about the efficacy of nursing handoff in a Midwestern trauma center's emergency department. The system changes included nursing handoff to the bedside at shift changes, using an adjusted scenario, context, assessment, suggestion communication tool. Handoff became a National Patient Safety Priority of the Joint Commission in 2006; the priority was to provide the reporting process with more structure to resolve miscommunication-related errors. (Bourgault, A. M.2019). Handoff is

characterized as active real-time communication for the transfer of specific information, expertise and patient responsibility from one health care team member to another for the continued safe care of patients. The Joint Commission published a Sentinel Alert Event entitled “Inadequate Hand-off Communication” in 2017, which highlighted the importance of standardized communication to achieve patient safety goals. (Bourgault, A. M.2019). Errors of interaction are involved in as many as two-thirds of hospital sentinel cases. Interaction errors that occur between shifts during handoff carry a high risk of causing patient harm. It has been shown that standardizing handouts boost their security. (Kesh, & Streiler,2019). Some advantages have been correlated with bedside hand-off involving patients and their families, including improved patient and family satisfaction, a better view of treatment and a better understanding of the condition of the patient. Studies have found that patients and their families have increased confidence and awareness, and that staff has fulfilled their needs. In a few studies, researchers have found that patients and their families have increased their confidence and knowledge. Bourgault, 2019

In a 504-bed community hospital, a survey conducted among 84 nurses to equate BSR with conventional non-structural studies scored BSR higher in all measures. BSR ranked 3.78 for patient participation, 3.85 for patient safety and 3.45 for details shared on a five-point scale, respectively, versus 2.64, 3.41, and 3.11 for non-structural data. In addition, by raising the score from 3.43 for conventional reporting systems to 3.8 20 for BSR as a new method for nurse handoff, BSR improved the transparency of nurses by 37% (Fitzpatrick & Small, 2017).

Bedside End-of-Shift Report

The start of the shift is the most significant event at the end of the nursing cycle. The sharing of patient information between nurses at shift change was an important process in clinical nursing practice, enabling nurses to share the required patient information to ensure continuity of care and patient safety. Handover report improves patient security and satisfaction; builds confidence between nurse and customer. (Kaur, Choudhary, & Sharma, 2019. Patients accept bedside change notifications as a privilege, as an opportunity to participate and to be at the center of the nursing care system. Nurses also could increase patient safety by designing and implementing bedside shift reports and to provide concrete evidence of the advances achieved by the nursing profession in recent years. (Bressan, Cadorin, Stevanin, & Palese, 2019).

Nelson (2016) did a study and found out that Pharmaceutical failures in the United States cause millions of deaths every year. During the transfer of treatment, miscommunication accounts for the highest number of such mistakes. During the shift change, the lack of patient participation in information exchange between nurses prevents the reliable and accurate exchange of information and risks the health of patients. Insufficient transfer of patient information to a hospital unit from one nurse to another can cause unnecessary permanent damage to the patient and even death. Walsh, Messmer, Hetzler, ‘Brien, & Winningham (2018) found out that through integrating bedside monitoring, patient satisfaction, transparency, and positive outcomes can be improved. Mitchell, Gudeczauskas, Therrine & Zauher (2018) found out that receiving end-of-shift report at the bedside avoided adverse events, including the initiation of a

rapid response when the state of the patient changed from the last representation during monitoring. Bedside reporting also allowed nurses to imagine what they were going into. Also, in addition to reporting, nurses can check the patient's IV site(s), pain control, safety measures, and awareness level with the off-care nurse.

BSR shortened the reporting period for nurses by 10 minutes, representing a reduction in annual overtime compensation from $95,680 to $143,520 (Dorvil, 2018). Stephens, Swanson-Biearman, Kerr & Whiteman, 2018). Since unplanned overtime is causing the facility's financial burden

Patients felt respected as nurses were handoff at the bedside. Studies have stated that patients respect nurses as supportive health care professionals on their bedside (Lupieri et al., 2016)

Local Background and Context

This prime interactive hospital is nonprofit situated in a suburban community on a stunning 40-acre site. This facility has a total of 100 private rooms for patients and 8 beds for intensive care units. They have special waiting areas for families and a dry, homely atmosphere. They deliver digital hospital technology which is that communities only planned digital hospitals. They make patient information accessible electronically, immediately, anywhere, wherever, across the campus. It reduces paperwork and redundant testing and helps clinicians to make more informed decisions faster and make best use of patient resources. The result is maximized protection for patients, more efficient treatment and quicker, more reliable contact between caregivers. Other features include advanced Medical/Surgical services, inpatient and outpatient, surgical suites, a 12

beds recovery unit, a 24-hour emergency department with 24 examination rooms, available VIP patient suites, telemetry unit, internet access to all the patient's rooms, gift shop, cafeteria, chapel, and community rooms. This project was carried out on their 26-bed telemetry care unit. This unit is staffed by RNs and CNAs together with an RN charging nurse unit. There is also a hospitalist nurse practitioner on the unit. Staffing comprises four to five RNs with the same number of CNAs for each shift. As a previous senior staff nurse at the critical care unit in this urban hospital, I know that this is ongoing problem, despite the implementation of BSR practice three years ago, most nurses continue to give report on the hallway/at the nurse's station, and at the medication room. There was an instant whereby an off-going nurse gave a report to the coming nurse at the nursing station and left, When the oncoming nurse went into the patient room, she found the patient unresponsive and the patient was coded and brought to the intensive care unit. I was the charge nurse.

Role of the DNP Student

I am a master's degree prepared family nurse practitioner. I am currently working with Nephron incorporated. I see office patients, taking care of their kidney problem. I also round on dialysis patients, adjusting their medications and treatment plans based on their monthly laboratory reports.

My inspiration to undertake this project was based on my experience working on the unit as a floor nurse staff, following the introduction of bedside report, I come across plenty of nurses finishing the shift report at the nurse's station. My other reason to undertake this project to improve awareness of nurses and increase the performance of

patients. I'm also excited about encouraging nurses to own their profession and being the health care providers ' eyes and ears. I assumed that raising awareness of how necessary it is to report at bedside would convince nurses on that unit to report at bedside ends of the shift. gathered and analyzed evidence from literature which was used to develop a teaching activity that was used for the training.

I explored current evidence and developed an education program for staff on BSR. The program followed the guidelines of Walden University DNP Manual for Staff Education Projects. As a DNP student, I planned, implemented, and evaluated the program. I shared the best BSR practices with the organizational leadership.

Role of the Project Team

The project team consisted of the clinical educator, the clinical unit manager and the clinical coordinator. The clinical nurse educator's, duty was to help both patients and co-workers. This clinical nurse educator acted as role model in a health-care environment and provides guidance to fellow staff. She strives to improve patient care and may be expected to make administrative decisions. She also conducts all the orientation in this unit with the help of the charge nurse who is also referred as the unit coordinator. The clinical nurse educator also creates a curriculum, teaches, guides, supports, conducts research, disseminates information through national presentations and publications, publishes grant proposals, serves in the activities or committees of the agency, and establishes standards within the clinical nursing environment

The clinical unit manager oversees the affair of the unit on daily bases. She manages all other staff members on the unit. The clinical coordinator makes and assigns

the assignment to the staff, and in the end, she makes sure the assignment is completed at the end of the shifts. She rounds with the doctor and other disciplinary team members and reports to the staff on the units, and the CNA assists patients with various activities of daily living. They perform these jobs in hospitals, nursing homes, and other medical facilities. They are responsible for activities such as bathing, dressing, and checking vital. The clinical coordinator oversees everything in the unit.

These projects include all staff members on this unit, the clinical unit manager, the clinical nurse educator, and the staff RN. The clinical unit manager, the clinical nurse educator, and the unit coordinators was the expert panel that reviewed the proposed education program after Walden Institutional Review Board approval. This project was given to all RN staff on the unit.

Working with the clinical nurse educator, unit coordinator and the clinical unit manager to raise awareness of the value of performing end of the shift report at the bedside boost the performance of the staff members on this unit. It also improved their confidence in delivering the quality care patients need and deserve It created a relationship between the patients and the staff. It also enhanced teamwork among the staff members.

Section 3: Collection and Analysis of Evidence

Introduction

The implementation of change in a health care organization can be challenging. Individuals tolerate change when they are confident with what they know but do not want to start learning new practices outside their comfort zone. Shareholders need to be included in project planning to help such individuals overcome their fears of the unknown and to ensure that the project developer succeeds in implementing the project (Hodges & Videto, 2011). Research has aimed to promote the use of evidence-based practices to enhance health care (Harvey et al., 2019). However, there is a gap in practice relating to bedside care, and much health care research cannot be integrated into practice (Sharp, Swaithes, Ellis, Dziedzic, & Walsh, 2020). Although health researchers acknowledge the challenges in the healthcare sector, they are still uncertain about how to use evidence-based research to help health providers, patients, and caregivers increase outcomes and quality of care.

Further, the nursing BSR allows both the incoming and outgoing nurses to evaluate the patients and examine any errors in the safety of the patients, and it makes it possible for patients to be part of their care plan. But the BSR is a new concept for many U.S. nurses, although most hospitals in the country implemented it many years ago. Recently, other institutions have implemented a zero tolerance on noncompliance with BSR following the standards of The Joint Commission. This is because, according to research, 180,000 Medicare patients died in 2010 due to less than competent medical services (Office of the Inspector General, Health and Human Services, 2015), and

between 210,000 and 440,000 patients who go to the hospital every year for treatment suffer preventable harm that contributes to their deaths (Ofori-Atta, Binienda, & Chalupka, 2015). Medical mistakes are also the third leading cause of death in the United States after heart disease and cancer (Ofori-Atta et al., 2015). This project may illustrate how the change summary goes through a metamorphosis, going from the nurse station to the patient's bedside. The aims are to increase health and to give patients a clearer view of their diagnosis and recovery plan.

Practice-Focused Question

The practice-focused question for this staff education program was "Will a staff education program on end-of-shift BSRs increase staff perceptions, knowledge and commitment to conducting daily end-of-shift reports at patients' bedsides?" I wanted to assess whether continuing education awareness and focusing on a mandated zero-tolerance policy enhances staff compliance with patient bedside end-of-shift reporting. A broad goal of the education program was to educate the staff on the value of BSR processes in delivering patient care. An anticipated outcome of this project is improvement in the quality of care and safety of patients by integrating them into a culture of safety at all levels of health care.

Nurses have a critical role to play in ensuring inpatient safety, and they need to be mindful of best communication practices. All nurses must prioritize the well-being of patients (The Joint Commission, 2017). I conducted an assessment on the behaviors of the nursing staff on a 26-bed telemetry unit that consists of new graduate novice nurses and competent nurses with 1 to over 10 years in nursing. After conducting a pretest, I

provided staff education under zero-tolerance policy to reduce noncompliance with conducting shift reports at the bedside. The objectives for the program included:

1. Assessing the status of BSR before an educational intervention.
2. Developing an educational intervention including a pretest–posttest evaluation of participants.
3. Conducting the training and the evaluation of the developed educational intervention.
4. Communicating the findings from the program to relevant others (nurses' leaders, etc.).

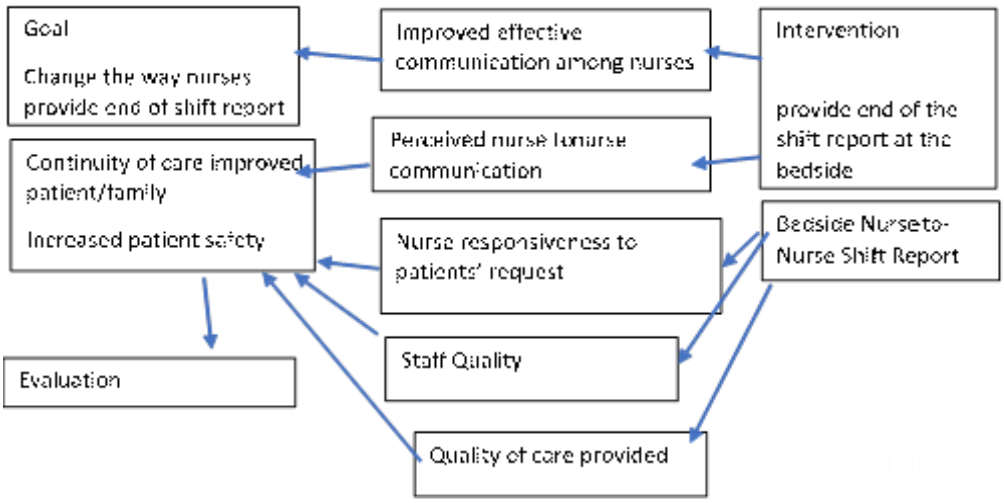


Figure 1. A flowchart illustrating the design of the staff education program.

Sources of Evidence

A comprehensive literature review was served as the initial step in reviewing the evidence. The literature demonstrates the problems that arise when nurses fail to

communicate effectively between outgoing and incoming nurses. Such miscommunication increases the potential for harm to patients or leads to a delay in treatment. (Rodziewicz & Hipskind, 2019). This project involved educating the nursing staff in the procedure and importance of BSR. Nursing theory, which provides a philosophical basis for the self-governance of nursing education and practice, will inform the development of the project. In developing the training, I integrated the theory of Malcolm Knowles on how adults learn; Knowles's (1973) nursing theory promotes the fundamentals of evidence-based research and positive patient outcomes in the profession. I also incorporated The Joint Commission's (2017) Sentinel Alert, which includes guidance on evidence-based practices. This alert advises communication in hand-off between senders and receivers, including communication between hospital caregivers and other healthcare facilities, as well as within and between hospital caregivers (The Joint Commission, 2017).

Knowles (1973) emphasized that adults are self-directed and bear decision-making obligations. Per Knowles, adults learn better with life experience. In this chapter, I reviewed the literature on errors resulting from miscommunication during shift reports. I discussed research on patient experiences with missed care due to a poor report during hand off.

To obtain literature for the review, I conducted database searches in CINAHL for literature about poor communication between healthcare workers and the effect on patients. In conducting a comprehensive search on the effectiveness of end-of-shift bedside reports, I used the following databases and search engines: CINAHL Plus with

Full-TEXT and PDF, Medline, Pub Med, Google Scholar, and Cochrane Reviews. Keywords includes, but not be limited to, *handoff, handoff training, team concepts, handoff communication*, *handoff report or miscommunication*, and *error or shift change*. Figure 1 illustrates the steps I used to gather the evidence.

At the beginning of the planning stage, I completed a pretest to evaluate what the anticipated participants knew and what they had to say about the end-of-shift report. At the end of the training, I completed a posttest to determine if there would be any improvement in staff learning and perceived willingness to report at the bedside. The unit charge nurse assisted me in posting an invitation in the telemetry break room. Reminders was sent by the charge nurse via e-mail to all staff. The education sessions were scheduled at convenient times based on staff schedules. The nursing leadership on the telemetry unit was invited to participate in an interactive educational program on their role in making sure the nurses adhere to their policy in giving BSR reducing the use of the nursing station and hallway in giving reports. I reviewed the organization's BSR policy and incorporated it into the staff education program. I encouraged the educational department to review the impact of the training in 3 months to ascertain whether the nurses are using the bedside report for end-of-shift reporting. I used a pretest/posttest method to evaluate changes in BSR.

The nurses were notified by de-identification that the data collection process will remain anonymous, the surveys were e identified as Nurse # 1, Nurse # 2, Nurse # 3, etc. The data was compiled before distribution to management so that individual nurses cannot be identified**.**

This project is aligned with the Walden University DNP Manual for Staff Education Projects. The facility signed the site approval form for the staff education doctoral project. All participants signed the consent form for anonymous questionnaires. The education commenced as soon as all requirement was obtained and confirmed.

Usually, in this unit, the new staff arrives 15 minutes before the start time, so they will have a brief huddle report from the off-going charging nurse alerting them to what is happening with the unit as a whole, after that brief report, individual nurses will then go to their respective off going nurse for their full report. I utilized that period to educate the staff as many times as possible.

Data was collected through pretest questionnaires and observation. Before training, nurses completed questionnaires answering questions that will assess their understanding of the end-of-shift reporting on their unit, their opinions on the new end-of-shift reporting process, and their opinions about what works well and what does not work well. The purpose of this DNP staff education is to create awareness on the importance of BSR versus reporting that takes place at the nursing station and in the hallway

Analysis and Synthesis

The data was compiled into an educational presentation for nursing management and employee review following analysis**.** PowerPoint method was utilized for the training. The project includes the use of printing and distributing a handout for the presentation. All nursing staff received the education and training and the training will

remain available to all nurses to complete for three weeks to account for staff members who may be on vacation.

Table 2

Teaching Plan

Goal	Objective	Activities
To assess the adaptability of the Nurse to Nurse Bedside End of the shift reporting in a Telemetry Unit	Assess behaviors and awareness of bedside reports among participants	Hold a conference to introduce Participants to the system. Offer the surveys in the form of a questionnaire to assess the awareness of the participants about bedside reporting, the responses and questions that they might have and to mitigate their anxiety. Observe participants report at the end-of-shift and complete checklist
	Assess the impact of changing attitude	Observe nurses give change updates on the bedside using the checklist. Let nurses answer the same questionnaire that they completed at the start of the education program

Summary

In Section 3, I defined the approach I used to conduct the evidenced-based education program on end-of-shift BSR performance. I examined the importance of practice-focused problems with the difference between the curriculum guidelines and actual practice. In this section, I also state the objectives for education. I addressed the sources of evidence, including organizational descriptions of key issues, requirements for inclusion, and respect for ethical security. I have outlined the planned route for calculating the results.

Section 4: Findings and Recommendations

Introduction

Nurses play a critical role in ensuring inpatient safety, and they need to be mindful of best communication practices. Nurses must also prioritize the well-being of patients (The Joint Commission, 2017). But it has been noted by several researchers that nursing staff often do not comply with standards regarding reporting at the patient's bedside (Gregory et al,2014). If the reporting process is taken to bedside, patients and families, including patient safety guardians, may be given an opportunity to hear and engage in information sharing (Alvarez, 2019). BSRs can have a positive effect on patient satisfaction and outcomes and can minimize overtime costs and budget shortfalls (Jafari, Sarvestani & Moattari, 2018). Other benefits of BSRs include promoting patient safety and giving the patient the opportunity to become more involved in their care (Sand-Jacklin & Sherman, 2014).

Despite the benefits of BSRs, this can be a new and daunting process for nursing staff. The overarching aim of this DNP project was to create awareness of the impact of BSRs and to encourage nurses to carry out a bedside shift report to enhance continuity of care and to improve communication between bedside nurses through development of an education program. The first objective was to assess the status of BSR prior to the formal training of staff using pretest to evaluate what the anticipant knew and what they have to say about the end-of-shift report. The second objective was to develop an educational program, including a pretest, posttest, and handout. The third objective was to evaluate the participants. This was accompanied by an analysis of the data gathered for evaluate

programmers' efficacy. The final objective was to draft recommendations to be shared with the unit and nursing representatives for strategic planning and ongoing program assessment. The BSR project was developed to enhance the improvement in the unit shift reporting process. Three years ago, in the southeast United States, a small rural hospital adopted a new policy mandating all nursing staff to conduct their end-of-shift reports at the bedside of patients, allowing patients and family members to participate in the report. However, most nurses continued to give end-of-shift report at the nurses' station rather than at the bedside. Thus, the practice-focused question for this staff education program was "Will a staff education program on end-of-shift BSRs increase staff perception of their knowledge and commitment to conducting daily end-of-shift reports at patients' bedsides?"

To obtain literature for the review, I conducted database searches in CINAHL for literature about poor communication between healthcare workers and the effect on patients. In conducting a comprehensive search on the effectiveness of end-of-shift BSRs, I used the following databases and search engines: CINAHL Plus with Full-TEXT and PDF, Medline, Pub Med, Google Scholar, and Cochrane Reviews. Keywords included, but were not limited to, *handoff*, *handoff training*, *team concepts*, *handoff communication*, *handoff report or miscommunication*, and *error or shift change* This project provided supportive education to reinforce the policy and the overall need for BSR. This section is intended to include a review of the findings and a discussion of the conclusions as well as the outcomes of the project.

Findings and Implications

The overall aim of this staff education development project was to enhance compliance with reporting at the patient's bedside and to improve awareness of the mandated zero-tolerance policy and the value of BSR processes in delivering patient care. The belief is that increased compliance with BSR will lead to improvements in the quality of care and safety of patients. The facility has considered initiating a zero-tolerance policy to reduce noncompliance with conducting shift reports. In response to this new policy, an educational intervention on BSR was provided to a sample of 15 nurses on a 26-bed telemetry unit.

Of the 15 non-randomly selected participants, most (93.3%) were female. Almost half (46.7%) were under 30 years of age, 40% were 30 to 50, and a small number (13.3%) were over 50 years of age. Most participants (86.7%) were bedside nurses. Two were in education or administrative roles. One identified as a senior level nurse administrator (6.7%), and one (6.7%) was a nurse educator. The majority (40%) had over 10 years of experience nursing. One third (33.3%) reported between 5 and 10 years of experience and only one in four (26.7%) had 4 or fewer years of experience. The typical respondent was a female, bedside nurse with over 5 years nursing experience (see Table 3).

Table 3

Demographic Description (N = 15)

Characteristic	*N*	Percent
Gender		
Female	14	93.3
Male	1	6.7
Age group		
Under 30	7	46.7
30-50	6	40.0
Over 50	2	13.3
Position		
Registered nurse (bedside)	13	86.7
Nurse educator	1	6.7
Nurse administrator	1	6.7
Years of experience in nursing		
Less than 5	4	26.7
5-10	5	33.3
Over 10	6	40.0

A pretest was administered at baseline before exposure to the educational sessions. Each participant attended one session of the five 45-minute educational sessions. The posttest was administered 1 week after attending all five sessions. There were therefore 6 weeks between the baseline and posttest data collection periods. Scores achieved before and after exposure the educational session were compared using a *t*-test analysis. The maximum possible score was 50 points. The scores achieved by the respondents ranged from 31-47 on the pretest and 40-50 points on the posttest. The cumulative baseline (pretest) score achieved for understanding the importance and utilization of the BSR was 39.0 points. After attending the five 45-minute sessions, the

sample scored an average of 47.27 points. This 8.27-point increase was statistically significant (t = 9.883, p = .001) using a Paired Samples t-test.

Each question item score on the scale was based on a 5-point Likert scale and could range from a value of 1 to a value of 5 per question item. The pretest scores received on the scale items ranged from 2-5 points. The posttest item scores ranged from 3-5 points. The average increase in question item scores ranged from a low of .3 to a high of 1.46 points. The item, *feeling that bedside shift reporting presented challenges*, did not change from before to after attending the training. The average pretest and posttest item scores as well as the difference between average pre and posttest scores are illustrated in Table 4.

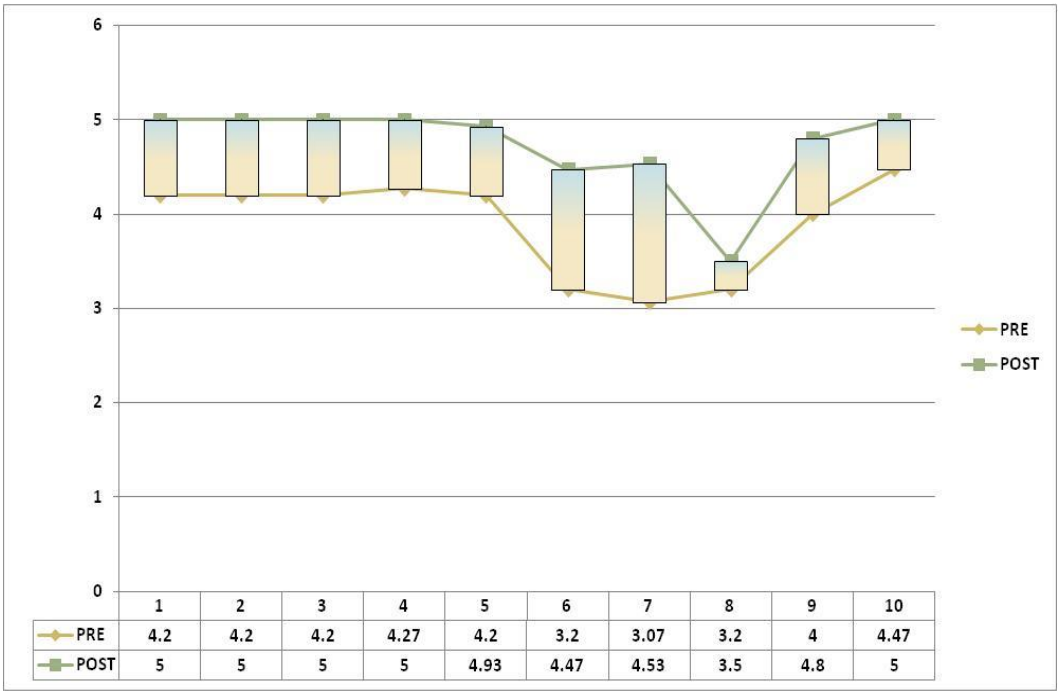
Table 4

Perceptions of Bedside Shift Report Utilization: Average Pre- and Post-Test Scores

Question	Pre	Post	Δ	Sig.
Bedside shift reports are an effective way to communicate.	4.2	5.0	.8	**
Bedside shift reports help to recognize changes in patient condition.	4.2	5.0	.8	**
Bedside shift reports help ensure transparency and accountability.	4.2	5.0	.8	**
Bedside shift reports promote involvement of patients in their care.	4.27	5.0	.73	**
Bedside shift reports improve the safety and quality of care of patients.	4.2	4.93	.73	**
Bedside shift reports are stress free.	3.2	4.47	1.27	**
Bedside shift reports are completed in a reasonable manner.	3.07	4.53	1.46	**
I feel that bedside shift reports present challenges.	3.2	3.5	.3	NS
I can clarify information that has been provided to me during bedside reports.	4.0	4.8	.8	**
Bedside shift reports improve patient and nurses' satisfaction.	4.47	5.0	.53	**

Note. **Significance level of $p < .01$; NS = Not Significant

A visual graphic illustrates that the widest pre and post differences were noted for Question 6 which rates the participant agreement that bedside shift reports are completed in a reasonable manner (+1.46). This was followed by Question 7 which asked the participants' agreement that a bedside shift reports are stress-free (+1.27). The smallest change was noted for Question 8, which asked the respondent to rate their agreement that a bedside shift reports present challenges. Figure 2 provides a visual illustration of the distances or difference between the pre and average post test scores by item on the scale.



	1	2	3	4	5	6	7	8	9	10
PRE	4.2	4.2	4.2	4.27	4.2	3.2	3.07	3.2	4	4.47
POST	5	5	5	5	4.93	4.47	4.53	3.5	4.8	5

Figure 2. Average pre and post test scores and differences for10 question items.

Key Findings

- A total of 15 participants were non-randomly selected. The vast majority (93.3%) were female and over 30 years of age 53.3%). Most were bedside nurses (86.7%) with five or more years' experience (73.3%).
- Each participant attended one section of the five 45-minute educational sessions and completed a pretest before exposure to the training sessions and a second post-test six weeks after attending one session of the five 45-minute educational sessions.
- A t-test estimated that the cumulative baseline (pre-test) score was 39.0 points and 47.27 points at follow-up. The 8.27-point increase was statistically significant ($t=9.883$, $p=.001$).
- The largest increase was noted for question 6 which rates the participant agreement that bedside shift reports are completed in a reasonable manner (+1.46) and question 7 which rates the participants' agreement that bedside shift reports are stress-free (+1.27).
- The smallest change was noted for question 8 which asked if bedside shift reports present challenges. All item changes were significantly higher except for question 8.

Implications for Practice

Future project activities in this setting could address how this educational program on bedside report may have influenced patient satisfaction. The current research

largely focuses on patient satisfaction as a result of training on reporting received by bedside nurses. The standardized reporting method for bed changes is a field that needs more study. There is an opportunity to identify the impact of a bed shift reporting system on patient safety, communication improvement, quality of care, and patient involvement for different types of handoff practices within various care units and organizational settings. In addition, incidents that occur during shift changes should be reviewed for their frequency and intensity to provide a clearer view of the program's effect on patient safety.

Implications for Social Change

Social change includes changes in human behavior, expectations as well as societal structure and functioning (Sanford, 2017). This form of change especially occurs in nursing when attitudes, outlooks, and assumptions are modified. Current research on this topic has determined that training on the use of standardized shift reporting has changed the perceptions and values of nurses about shift reporting procedures. (Scarborough,2019). Nurses working at this healthcare facility typically reported in the office, hallway or in the corridor before the education on BSR was conducted. There has been a shift in behavior of nurses going from a nurse-centered report to a patient-centered one that is structured and completed at bedside. Education training on BSR also fosters positive social change in the care facility by promoting communication improvements and quality of care. The change in practice has made it easier for patients and their family members to understand the treatment plan and what to expect post-treatment. Improved communication is likely to result in increased patient satisfaction with the care provided

and carries the potential to encourage use by the community as a consequence of satisfaction, thereby financially benefiting the hospital.

Recommendations

An analysis of the finding led me to outline recommendations for the DNP project team. The leadership team is encouraged to provide nursing staff with regular training on the importance of BSR. I anticipate that initially, some staff members will participate in reporting at the bedside but will return to the current reporting practices away from the patient bed unless nursing management reinforces the importance of the evidence-based approach to staff reporting. Another recommendation is that leadership continues to track performance and to initiate interventions to improve compliance with clear BSR standards **(**McAllen, Stephens, Swanson-Biearman, Kerr & Whiteman, 2018).

The fields of medicine and healthcare are continually developing. Education and other ways of sharing this information are important for advancing the use of evidence-based treatment and positive patient results. Implementing changes in strategies in practice as well as teaching nurses about how to recognize the need for change is essential for improving patient outcomes. Finally, it is recommended that leadership randomly observe staff performing BSR in order to make sure they are following the guideline recommended by joint commission. Assuring that the recommended guidelines carry social value in that the results of this project will benefit the staff, the hospital system, and the patients when project results are shared. The positive social change from this project has potential to impact is to improve patient care and quality outcomes (Mohammed & Elhadi, 2019). Other benefits of BSR are diverse, including increased

patient engagement and understanding of treatment, decreased patient and family anxiety, decreased “departure” feelings during shift changes, increased nurse transparency, increased teamwork and nursing relationships, and decreased potential (Mohammed & Elhadi, 2019).

Contribution of the Doctoral Project Team

The team had an integral role to play on the project under my direction. The unit coordinator assisted in distributing the fliers and making the announcement for the upcoming dates for the training. The unit educator reviewed the PowerPoint presentations used for the training sessions to make sure they were valid and in alignment with the objective of the project. The unit educator also encouraged all nurses in the unit to attend the training. The unit manager contributed to the project by presenting in one of the training sessions. The entire team was extremely helpful and instrumental with carrying out the project.

Strengths and Limitations of the Project

Strengths

There were two main strengths identified in this project. The first strength relates to consistent support from the management of the health care facility during all the project implementation phases. The unit managers, nurse educator, and unit coordinator had a high degree of dedication and involvement. Their commitment was a significant reason for the success of the current project. The second strength concerns effective teamwork skills among the nurses who participated in this project. There was support and encouragement from peer to peer that led to the projects’ success.

Limitations

Several limitations were identified in this project. First was the small sample size. The limited number of project participants can cause a concern for drawing conclusions and impacts the ability to generalize the results to the population from which the sample was drawn. There is a chance that the nurses within the hospital unit who participated in the surveys were not representative of all nurses in the unit, other units in the facility, or other facilities. The nurses involved in this project were from one unit, thus restricting the ability to generalize the outcomes.

The second limitation of this project concerned the self-reporting of nurses' perceptions about practice. Self-reported results could be influenced by a bias in social desirability where the 15 participants want to provide favorable answers (Sanford, 2017). Respondents may have sought to provide answers in a way that would have been regarded favorably by the project leader. Furthermore, after completing the questionnaires, the participant's' feelings may have skewed the self-report questionnaire. The nurses gave their views on what they believed were obstacles to bedtime reporting. Third, the opinions and actions of the nurses may be affected by what was shared with fellow staff members. The nurse's reactions may have been biased by what they felt they learned. Many nurses from this setting float from floor to floor according to the census and may face similar or different barriers to BSR.

It is highly recommended that future projects addressing the topic of training on standardized BSR conduct their study in a practice environment in which the management and peers are supportive of the project at all phases. Their commitment will

be significant for the success of their project. Future studies should use a larger sample size and nurses selected from different types of facilities in order to provide enough power to detect differences when they exist and to improve the ability to generalize the outcomes. Further analysis is required to assess the effect of this project on the level of patient satisfaction. The present analysis reflects only on the experiences of nurses. Longitudinal studies could also be performed to assess if the results of this program lasted longer than the time period in this analysis. In order to carry out further research, the report can be used to create the units that have the lowest and the highest rates of compliance.

Section 5: Dissemination Plan

It is necessary that doctoral holders be able to disseminate research results to health practitioners and other stakeholders in the health care field. The dissemination of scholarly results involves communicating the project's results so that similar conditions can be extended towards the enhancement of patient safety (Oermann & Hays, 2015). The sharing of results offers researchers the ability to share their accomplishments as well as the problems they have faced in the study process. The dissemination of research is a significant first step on the road toward translating information and improving practice (Edwards, 2015). Researchers are often encouraged, where appropriate, to create tailored communications about their research for key stakeholders and improve information translation through systematic assessments, development of guidelines, and communication through frameworks of practice. (Edwards 2015). The results of the project will be disseminated both by internal and external approaches. The results will be disseminated orally to key stakeholders during the internal meeting and in the quarterly newsletter of the organization

The dissemination of the findings of this project is vital to the process of improving the standard of nursing practices; therefore, it is important to encourage open access to scholarly findings. The team had an essential role to play in the project under my leadership. The unit supervisor helped in the delivery of the flyers and the announcement of the forthcoming training dates. The unit instructor reviewed the PowerPoint presentations used for the training sessions to ensure that they were relevant and consistent with the goals of the project. The unit instructor also urged all nurses in

the unit to take part in the training. The unit manager contributed to the project by discussing it in one of the training sessions. The whole team was supportive and instrumental in carrying out the project.

Analysis of Self

The DNP program has improved my leadership skills. The program has given me experience to be used as a scholar–practitioner. BSR can be challenging and frustrating if a nurse is not prepared. I became a licensed practical nurse in 1992 and an RN in 2002 and since then I have endeavored to learn more about nursing through education and by hands on experience. My skills and knowledge are credited to many years of education and training. The experience and skills gained during my DNP journey has supported my growth as a nurse who is able to use evidence to support practice based on research. The fundamentals of the DNP curriculum are to encourage graduate nurses to design, implement, and evaluate health outcomes in different settings. The DNP project has engrained important methodological skills in designing and assessing research that seeks to improve public health.

As a Practitioner

I have grown as a clinician, as a scholar, and as a person. The nurse practitioner program has provided me with new knowledge and skills that will support me in my current position as a nurse preparing for doctorates. I have learned about different leadership positions in the setting of health care and applied evidence-based results at the bedside leading to a shift in practice. The introduction of this staff education initiative aimed at improving the report on bedside shifts has helped me to put into practice the

skills gained from the doctoral program. The use of Malcolm Knowles's theory of adult learning mechanism helps to identify how adults learns. I was able to utilize the five axioms about how adult learn to create the training material for the education.

As a Scholar

The DNP program led me to a personal discovery, mastering the way to conduct research and become a scholar. As an advanced nurse, the DNP project gave me the opportunity to translate and incorporate expertise into clinical practice, which is a prerequisite for a doctoral qualified nurse. During the project implementation process, I have acquired research skills, and my self-confidence as a scholar has also increased as a result of study. I will remain committed to scholarly development by continuing education and engaging in nursing studies to keep up with current nursing practices. I had practical knowledge of conducting surveys and performing both descriptive and inferential statistical studies. The data collection and analysis method has made a major contribution to my academic development.

As a Project Manager

As a doctoral student, I have completed my education by increasing awareness about the effect of end-of-shift BSRs, thus enhancing coordination and quality of care within the organization. The DNP program allows students to define a significant practical problem based on his or her expertise and interest and to apply the information gained through the program to address the problem. At the conclusion of the shift BSR project, I had the first opportunity to investigate and deal with a nursing problem. Just as I reflect on the processes involved in completing the project, I must admit that each part

of the project has taken on a fresh yet overwhelming experience. Carrying out the project's education training was a challenging task that required dedication and time. I had to establish good relationships with different stakeholders to ensure that the project was successful. This experience gave me an opportunity to bring theory into practice in order to attain the project objectives.

Summary

The development of an education program to raise awareness among health care staff about the importance of BSRs was intended to enhance communication between nurses, physicians, and patients. Staff may increase their awareness of the value of BSRs and be able to engage in them routinely. Reporting at bedside at the end of the shift is mandated by the Joint Commission. (Foster, Abraham, & Gillum, 2019), as ineffective communication continues to be the leading cause of sentinel incidents in hospital settings. (Naz, Sehr, Afzal, Amir-Gilani, & Ayaz, 2019). The dissemination of the project's results are important for enhancing the standard of nursing practices. I hope to publish my results in ProQuest as suggested by Walden University, a peer-reviewed journal focused on improving the quality of care given to patients.

References

Amer, K. S. (2019). Clarity and safety in communication. In E. Arnold and K. Boggs (Eds.), *Interpersonal relationships: Professional communication skills for nurses* (pp. 17-33). St. Louis, MO: Elsevier.

Andersson, Å., Frank, C., Willman, A. M., Sandman, P. O., & Hanson, G. (2018). Factors contributing to serious adverse events in nursing homes. Journal of clinical nursing, 27(1-2), e354-e362. https://doi.org/10.1111/jocn.13914

Bressan, V., Cadorin, L., Stevanin, S., & Palese, A. (2019). Patients experiences of bedside handover: Findings from a meta-synthesis. *Scandinavian Journal of Caring Sciences, 33*(3), 556-568. doi:10.1111/scs.12673

Bourgault, A. M. (2019). Are patients and family members an essential aspect of bedside handoff. *Critical Care Nurse*, *39*(3), 10-12. doi:10.4037/ccn2019481?

Campbell, D., & Dontje, K. (2019). Implementing bedside handoff in the emergency department: A practice improvement project. *Journal Emergency Nursing, 45*(2),149-154. doi:10.1016/j.jen.2018.09.007

Cairns, L. L., Dudjak, L. A., Hoffmann, R. L., & Lorenz, H. L. (2013). Utilizing bedside shift reports to improve the effectiveness of shift handoff. *The Journal of Nursing Administration, 43*(3), 160-165. doi:10.1097/nna.0b013e318283dc02

Dorvil, B. (2018). The secrets to successful nurse bedside shift report implementation and sustainability. *Nursing Management, 49*(6), 20. doi:10.1097%2F01.NUMA.0000533770.12758.44

Edwards D. J. (2015). Dissemination of research results: On the path to practice

change. *The Canadian Journal of Hospital Pharmacy*, *68*(6), 465-469. doi:10.4212/cjhp.v68i6.1503

Evans, D., Grunawait, J., McClish, D., Wood, W., & Friese, C. R. (2012). Bedside shift-to-shift nursing report: Implementation and outcomes. *MEDSURG Nursing*, *21*(5), 281-292. Retrieved from http://www.medsurgnursing.net/cgi-bin/WebObjects/MSNJournal.woa

French, P. B. (2019). Culturally relevant practice framework and application in adult education. Retrieved from https://newprairiepress.org/cgi/viewcontent.cgi?article=4151&context=aerc

Harvey, G., Gifford, W., Cummings, G., Kelly, J., Kislov, R., Kitson, A., ... Ehrenberg, A. (2019). Mobilising evidence to improve nursing practice: A qualitative study of leadership roles and processes in four countries. *International Journal of Nursing Studies*, *90*, 21-30. doi:10.1016/j.ijnurstu.2018.09.017

Hodges, B., & Videto, D. M. (2011). Assessment and planning in health programs. London, England: Jones & Bartlett Learning.

Kannampallil, T. G. (2018). *Communication as sequences: Evaluating the structure and content of patient handoff communication* (Doctoral dissertation https://hdl.handle.net/10027/23303).

Kaur, R., Choudhary, R., & Sharma, P. (2019). A descriptive study to assess the practices related to end of shift handover among staff nurses working in selected hospitals of district Mohali, Punjab with a view to develop handover giving sheets. *Asian Journal of Nursing Care Qual*ity, *34*(3), 256-262. doi:

10.1097/NCQ.0000000000000357

Kesh, S., & Streiler, K. (2019). Improving handoffs by incorporating a standardized IPASS section into the written handoff document. Retrieved from https://scholarlyexchange.childrensmercy.org/cgi/viewcontent.cgi?article=1072&context=researchdays

Khan, A., Furtak, S. L., Melvin, P., Rogers, J. E., Schuster, M. A., & Landrigan, C. P. (2017). Parent-provider miscommunications in hospitalized children. *Hospital Pediatrics*, *7*(9), 505-515. doi:10.1542/hpeds.2016-0190

Lupieri, G., Creatti, C., & Palese, A. (2016). Cardio-thoracic surgical patients' experience on bedside nursing handovers: Findings from a qualitative study. *Intensive and Critical Care Nursing*, *35*, 28-37. doi:10.1016/j.iccn.2015.12.001

Manges, K. A., & Groves, P. S. (2019). Exploring the hidden functions of nursing bedside shift report. *Journal of Nursing Care Quality*, *34*(3), 256-262. doi:10.1097/NCQ.0000000000000357

Mitchell, A., Gudeczauskas, K., Therrien, A., & Zauher, A. (2018). Bedside reporting is a key to communication. *ARCHIVOS DE MEDICINA*, *3*(1), 13. doi:10.4172/2472-1654.100124

McAllen, E. R., Stephens, K., Swanson-Biearman, B., Kerr, K., & Whiteman, K. (2018). Moving shift report to the bedside: An evidence-based quality improvement project. *OJIN: The Online Journal of Issues in Nursing*, *23*(2). doi:10.3912/OJIN.Vol23No02PPT22

Naz, S., Sehr, S., Afzal, M., Amir-Gilani, M., & Ayaz, M. (2019). How to improve

ineffective communication among care providers which leads to medication errors in hospital settings, using lean six sigma (LSS) and total quality management (TQM)–A review. *Oncol Cancer Case Rep*, *5*(3), 155. Retrieved from https://www.iomcworld.org/open-access/how-to-improve-ineffective-communication-among-care-providers-which-leads-to-medication-errors-in-hospital-settings-usin.pdf

Ofori-Atta, J., Binienda, M., & Chalupka, S. (2015). Bedside shift report: Implications for patient safety and quality of care. *Nursing2019*, *45*(8), 1-4. doi:10.1097/01.NURSE.0000469252.96846.1a

Patel, S. J., & Landrigan, C. P. (2019). Communication at transitions of care. *Pediatric Clinics of North America*, *66*(4), 751-773. doi:10.1016/j.pcl.2019.03.004

Purwanti, E. (2017). Understanding the EFL Lecturers' Beliefs about Their Professional Learning from the Lens of Malcolm Knowles Theory of Andragogy. *Journal of Foreign Language Teaching and Learning*, *2*(1), 30-43. doi:10.18196/ftl.2117

Reese, J., Lewandowski, K. M., Rick, A. M., Brockel, M., Kulungowski, A., & Hyman, D. (2018). Improving interdepartmental handoff communication between the medical, anesthesia, and surgical teams to prevent patient harm—A quality improvement study. doi:10.1542/peds

Rucker, A., Rucker, A., & Windemuth, B. (2019). Utilizing team strategies and tools to enhance performance and patient safety (TeamSTEPPS) to improve ineffective communication in long-term care settings. *Journal of the American Medical Directors Association*, *20*(3), B26. doi:10.1016/j.jamda.2019.01.097

Sand-Jecklin, K., & Sherman, J. (2014). A quantitative assessment of patient and nurse outcomes of bedside nursing report implementation. *Journal of Clinical Nursing, 23*(19/20), 2854-2863. doi:10.1111/jocn.12575

Schirm, V., Banz, G., Swartz, C., & Richmond, M. (2018). Evaluation of bedside shift report. A research and evidence-based practice initiative. *Applied Nursing Research, 40,* 20-25. doi:10.1016/j.apnr.2017.12.004

Sharp, C. A., Swaithes, L., Ellis, B., Dziedzic, K., & Walsh, N. (2020). Implementation research: Making better use of evidence to improve healthcare. *Rheumatology, 59*(8), 1799-1801. doi:10.1093/rheumatology/keaa088

Tennant, M. (2019). *Psychology and adult learning: The role of theory in informing practice*. New York, NY: Routledge.

Walsh, J., Messmer, P. R., Hetzler, K., O'Brien, D. J., & Winningham, B. A. (2018). Standardizing the bedside report to promote nurse accountability and work effectiveness. *The Journal of Continuing Education in Nursing, 49*(10), 460-466. doi:10.3928/00220124-20180918-06

Waters, V. L. (2019). Team concepts: How to promote and hardwire bedside patient handoff. *Nursing Management, 50*(8), 7-9. doi:10.1097/01.NUMA.0000575340.23948.51