A PATIENT-CENTERED BEDSIDE REPORT: in the Medical Surgical Division

by Laura Vento, MSN, RN, CNL

Laura Vento, MSN, RN, CNL, is the Assistant Nurse Manager of Medical Surgical Quality. Laura joined UC San Diego Health System with an MSN from University of Virginia, having a previous bachelor's degree in Health Sciences from James Madison University. She is certified as a Clinical Nurse Leader.

Evidence-based practice (EBP) is an increasingly familiar theme among nurses. Integrating these best practices at the bedside continues to pose numerous challenges. Barriers to participating in EBP include: the nurse does not feel empowered, a perceived lack of time to change practice and a lack of awareness of research. Utilizing unit-based practice councils (UBPC) as a structure to foster a spirit of inquiry and navigate an evidence-based practice model was one strategy used to implement bedside report among six inpatient units in the Medical-Surgical division.

In 2011, the division-wide EBP journey began with individual UBPC library trips and consultations with the UC San Diego nursing research librarian, Mary Wickline. The first unit to undertake this was 5 West, a trauma progressive care unit. Their focus of research was shift handoff communication.

Faye Rivera, the 5 West UBPC chairperson reports, "At that time, we were transitioning from a telemetry unit to a trauma progressive care unit. Our hand-offs were not standardized and with more critically ill patients being admitted to the unit, we sometimes missed important information."

Practice council members attended a presentation by Dr. Caroline Brown, discussing EBP basics and how to appraise nursing research. This expert support fostered nurses' confidence and engagement in their project.

Faye recalls, "Based on our research and interviews of patients and co-workers, we decided we needed to create a standardized structure and process to bedside report. We started with the "Situation, Background, Assessment, Recommendation (SBAR)" communication format, and then added other elements specific to our unit."

At the beginning, change was not easy. With the full support of the UBPC, members championed the project, modeled and encouraged staff to go to the bedside and use the standardized tool. After a short evolution period, nurses embraced bedside report.

Faye found "There were many patient safety issues that were caught at bedside report. A medication error was caught and a patient's IV drip rate was corrected. That's when nurses realized the benefits from a structured bedside report."

The project yielded positive outcomes, including increases in patient satisfaction survey responses in the

Bedside Report Action Items Timeline

Action	Unit	Time Frame
Administer Nursing Satisfaction pre-implementation Quiz	5w, 8th floor	by Jan 6
	10e, 11w	unitl Jan 20
	6e, 6w	until Feb 3
With Project Manager finalize audit form (using universal audits plus anything unit specific ex. Pain, white boards, ect.)	5w, 8th floor	by Dec 31
	10e, 11w	by Jan 6
	6e, 6w	by Jan 20
With Project Manager create nurse education of bedside report rollout	5w, 8th floor	by Dec 31
	10e, 11w	by Jan 6
	6e, 6w	by Jan 20
Roll out nursing education	5w, 8th floor	Dec 23-Jan 6
	10e, 11w	Jan 7- Jan 20
	6e, 6w	Jan 21- Feb 3
Bedside report rollout with leadership support	5w, 8th floor	Jan 7- Jan 20
	10e, 11w	Jan 21- Feb 1
	6e, 6w	Feb 4- Feb 15
Weekly peer audits x1 month	5w, 8th floor	Jan 21- Feb 21
	10e, 11w	Feb 2- March 2
	6e, 6w	Feb 16-March 16
Monthly peer audits	5w, 8th floor	starting March
	10e, 11w	starting March
	6e, 6w	starting April

areas of "nurses overall,""nurse kept you informed," and "skill of the nurse."

Nursing satisfaction with handoff also improved. The most dramatic improvements reported by nurses were nurse accountability and time of report. The nurses of 5 West presented their findings at the 2012 UC San Diego Research and EBP Conference.

This project attracted the attention of bedside nurses and med-surg leadership. The leadership team conducted a division-wide observation study to assess shift report. This study revealed bedside report was occurring sporadically or not at all on the five other med-surg units. When report was given at the bedside, the patients were rarely involved. To integrate the positive outcomes of 5 West's project, a divisional bedside report initiative was created leveraging the UBPCs in the same way 5 West had.

One UBPC member was nominated from each council to serve as the bedside report project manager. They reviewed the current literature and developed standardized tools for bedside report using 5 West's as a template. Adopting evidence-based practices at the unit level required the integration of current evidence, clinical expertise, and patient and caregiver perspectives. UBPCs served as forums for discussing and incorporating caregiver perspectives. Members trialed the tool and customized it with unit specific patient needs.

For example, Darleen Parjarillo, bedside report champion for the 8th floor orthopedic unit, added the joint replacement clinical pathway to their tool. This is critical information in shift report for this unit. The individualization of the bedside report templates in UBPCs optimized the process for each unit. Additionally, a greater sense of ownership was created.

Basic elements of bedside report were incorporated into each unit's template to ensure a level of standardization among units. As nurses float among units the processes of bedside report would be the same with unit specific details. To audit bedside report on all med-surg units, the task force elected six universal processes of beside report to audit.

Faye replies, "For auditing, we decided on elements of bedside report that would be done on all units, like opening Epic (our electronic medical record) at the bedside. We included asking the patient what their goal is for the shift. We also added an audit question "Was this a 3-way report between both nurses and the patient?" to ensure we were actively involving the patient."

The task force developed an implementation plan that included bedside champions and management. This plan focused on coaching and modeling bedside report for two weeks on each unit during both day and night shift change. After the initial two weeks of the project rollout, peer-to-peer audits were conducted weekly for one month.

Initial outcomes are promising. Five of six units have increased patient satisfaction scores in "nurses kept you informed" in the first month of implementation. Incidence of nurses clocking out late is trending down as nurses become accustomed to the new standardized handoff process. Nurse satisfaction will be reassessed at 6 months.

Many patient safety issues have been caught at bedside report. Patient falls have been prevented, incorrect "no blood draw/blood pressure" limb identification was caught, and inadvertently clamped IV antibiotics

have been restarted in a timely manner.

Nurses have expressed surprise at hearing patient's priorities for the shift were as simple as having their hair washed or sitting in a chair when they ate dinner. Asking this question has helped develop the patient-nurse relationship, building trust and accountability.

Faye presented 5 West's adoption of bedside report and its influence on other units at the 2013 Nursing Innovation and Inquiry Conference. In her "lessons learned" slide, Faye credited shared governance structures and leadership at all levels for facilitating innovation evidence-based practice at the bedside. UBPCs also have provided a structure for project managers to report out process and outcome measures, address barriers and promote sustainability.