UNIVERSITY OF CALIFORNIA

Los Angeles

Utilizing a Standardized Approach to Nurse Shift-to-Shift Care Transitions Based on a Modified Version of the AHRQ Bedside Shift Report Checklist

A dissertation submitted in partial satisfaction of the

requirements for the degree

Doctor of Nursing Practice

by

Nathan A. Barfield

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ABSTRACT OF THE DISSERTATION

Utilizing a Standardized Approach to Nurse Shift-to-Shift Care Transitions Based on a Modified Version of the AHRQ Bedside Shift Report Checklist

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Doctor of Nursing Practice

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Background: In response to the Joint Commission's 2006 National Patient Safety Goal aimed at improving communication and handoffs in patient care, many healthcare organizations have adopted bedside shift reports. The Agency for Healthcare Research and Quality developed an evidence-based resource, the Nurse Bedside Shift Report Implementation Handbook and Checklist, that organizations can use to implement a standardized handoff practice. Despite the benefits of bedside report, many healthcare organizations have encountered challenges with its implementation and sustainment due to barriers such as time constraints, privacy concerns, interruptions, and distractions. **Objectives**: The Doctor of Nursing Practice Scholarly Project

aimed to evaluate the effectiveness of implementing a modified bedside shift report in a critical care setting using both qualitative and quantitative methods. The project aimed to implement a modified bedside report where information was exchanged outside the patient's room, and essential safety updates and introductions occurred at the bedside. This approach aligns with emerging evidence that supports safety goals while addressing staff and patient concerns about bedside reports, offering a practical path to sustaining effective handoffs and improving care transitions. The Agency for Healthcare Research and Quality bedside report checklist was modified to support a two-part handoff process. **Methods:** Thirty pre-/post-observations of the handoffs were completed. A pre- and post-survey consisting of 38 questions was completed to gain a better understanding of nurses' perceptions regarding whether a modified bedside report could serve as an alternative to a full bedside report. Independent sample t-tests were conducted to compare pre- and post-implementation survey responses on a five-point Likert scale. **Results:** Nine survey items demonstrated statistically significant improvements following implementation. Notably, consistent completion of the unit's standardized shift handoff process, nurse satisfaction with the handoff process, and nurses electing the modified handoff process over the full bedside report. Qualitative data collected through open-ended survey responses, one-on-one interviews, and focus groups were analyzed using a thematic analysis approach. Recurring themes included barriers such as interruptions, language barriers, time constraints, and privacy concerns. **Conclusion:** The findings support the adoption of a modified bedside report as a nurse-driven, patient-centered approach to shift-to-shift care transitions, aligning with organizational goals for improved communication, workflow efficiency, safety, and nurse satisfaction. These results highlight both the value and challenges of standardizing handoff practices in a high-acuity environment, offering a framework for sustainable implementation.

The dissertation of Nathan A. Barfield is approved.

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2025

This dissertation is dedicated to my family, friends, and loved ones. Thank you for your love, support, kindness, and understanding.

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Miami Neuro Symposium	Baptist Health (Miami, FL)	2016, 2017, 2018, 2019, 2022
Brain Attack Symposium	UCLA Health (Los Angeles, CA)	2017, 2019, 2022, 2025
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Advanced Nursing Leadership Academy Nursing Leadership Academy	Institute for Johns Hopkins Nursing (Baltimore, MD)	2018 2017
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Hospital Accreditation Essentials	Joint Commission (Las Vegas, NV)	2017

CHAPTER ONE: INTRODUCTION

The Joint Commission, a leading authority in healthcare, implemented a National Patient Safety Goal in 2006 aimed at improving effective communication and ensuring safe patient handoffs. The handoff is the transfer and acceptance of patient care responsibility through communication between caregivers, a process crucial for maintaining the continuity and safety of patient care and reducing errors (Joint Commission, 2017). Although the Joint Commission provides eight tips for completing high-quality handoffs (See Appendix A), it has not endorsed specific handoff tools or methods for reports; however, the process has been operationalized in many hospitals worldwide through the patient-centered bedside shift report (BSR) or bedside handoff (BSH). The standardization aligns with the goals of organizations dedicated to improving healthcare quality and safety, such as the Agency for Healthcare Research and Quality.

The Agency for Healthcare Research and Quality (AHRQ) advocates for high-quality, safe healthcare. The AHRQ leads federal efforts in healthcare research and provides tools to translate findings into practice, inform policies, and promote safe healthcare (AHRQ, 2022). Recognizing the significance of BSR handoffs, the AHRQ developed an evidence-based resource, the Nurse Bedside Shift Report Implementation Handbook and Checklist, that organizations can use to implement a standardized handoff practice (AHRQ, 2013). For over a decade, the implementation handbook and checklist have guided organizations on how to perform BSR.

According to the AHRQ and the Joint Commission recommendations, many healthcare organizations have implemented variations of BSR or BSH to improve care transitions between

staff nurses, enhance safety, and boost patient satisfaction. The terms BSR and BSH were used interchangeably in the DNP Scholarly Project. The BSR is most often conducted with oncoming and off-going nurses completing the report process in the patient's room in front of the patient and their family. This includes discussing the patient's medical history, current assessment, and ongoing care plan at the bedside with patients. BSH allows face-to-face interaction, introduction of the oncoming nurses, assessment, and clarification of incorrect information to improve communication and encourage patients to become active in their care (Mardis et al., 2016). Other benefits include asking the patient about their concerns, visually checking on the patient and the environment, and allowing the patient to hear about their care (Burton et al., 2016). Despite the many benefits of BSR, strategies for implementation, and BSR tools reported in nursing literature over the last twenty years, there have been mixed results with BSR across healthcare organizations.

Although some organizations have successfully implemented and sustained BSR, many have faced challenges. Malfait et al. (2018), who conducted observations of BSR, reported that one-third of the time nurses did not conduct report at the bedside, and another one-third of the time patients were not actively invited to participate in BSR. Chien et al. (2022) found that even though hospital guidelines typically mandate BSR, most handoffs occurred outside patient rooms in the hallways or at nursing stations. The authors also reported that even when nurses conducted the reports at the bedside, they often failed to invite patients or family members to participate and awkwardly discussed them as if they were not present (Chien et al., 2022). Other challenges often include patients who do not fully understand the handoff process, disruptions during the report, nurses not wanting to question their coworkers in front of patients or families, and difficulties integrating BSR into organizational culture. Nurses often report that BSR is time-

consuming, there are privacy concerns, they must explain medical jargon to patients, and some staff lack the skills or have anxiety related to performing BSR (Mardis et al., 2016).

Another challenge may be BSR itself. Perhaps BSR lacks the practicality and functionality to promote sustainability. Not only are there challenges with implementing bedside reports, but there are also challenges with sustaining them, despite the positive nursing literature touting their benefits (Dorvil, 2018). Completing a full BSR is not the only way to complete the shift-to-shift care transition between nurses.

Emerging evidence from patients and staff nurses supports the use of blended BSR as an alternative to full BSR for shift-to-shift transitions of care. The blended, modified, or partial bedside report is where the history and details about the patient's care are discussed outside the patient's room, and safety handoffs and updates are conducted with the patient inside their room. The modified BSR enables nurses to exchange information without interruptions from patients and their families. Grimshaw et al. (2020) recommend that nurse leaders allow staff nurses to divide BSR into two sections, where the main report and sensitive information are discussed outside of the patient's room, and introductions and safety checks are done at the bedside. Webster et al. (2024) found that modified BSR, with a focus on standardized communication, can improve safety-related outcomes. The modified BSR allows for uninterrupted communication, benefits the handoff process, and aligns with the Joint Commission's goal of minimizing disruptions during the transition of care (2017).

Martini and Resek (2021) studied the use of a blended BSR in a neurosurgical intensive care unit. The authors completed a pre-and post-intervention survey and found that 100% of nurses agreed or strongly agreed that blended BSR promoted patient safety compared to full BSR. They separated the blended BSR into three parts including a handoff outside the patient's

room, a patient safety check, and a room/environment assessment. The implementation of a blended BSH not only improved quality and safety but also enhanced patient engagement and satisfaction. Many patients appreciate the reassurance of nurses checking on them during handoff, sharing essential updates about their care, and involving them in the process. McCloskey et al. (2019) reported that BSH enables patients and families to contribute valuable information and better understand their care plan. They recognized that organizations cannot ignore the disapproving feedback about BSR from nurses and patients and must exercise some flexibility in how BSR is conducted. Utilizing a modified BSR may help organizations overcome challenges with BSR and provide a solution to sustain the practice, leading to improved patient safety and nurse and patient satisfaction.

Problem Statement

Bedside shift reports are recommended for enhancing patient safety and communication during care transitions. Mardis et al. (2016) conducted a systematic review of 41 articles focused on nursing handoffs in various units across the United States, Australia, Canada, and Italy. They concluded that BSR could improve patient experience. Many hospitals have implemented BSR to enhance patient experience and safety benefits. However, various challenges make it difficult to hardwire the behavior and sustain this practice.

In the selected organization, a Fishbone Cause and Effect Diagram (See Appendix B) was completed to understand the main reasons the organization has difficulty maintaining BSR consistency. The most notable challenges are people, processes, environment, technology, management, and audits. Examples related to people include resistance to change, inadequate training, and lack of engagement. Variables in the process include a lack of standardization, the complexity of reports, and time constraints, which lead to inconsistent completion of BSR.

Environmental factors that make completing BSR difficult include distractions and interruptions, patient privacy concerns when in shared rooms or when visitors are present, and a lack of educational materials, such as posters or brochures, that inform patients about the BSR process and how they can become active participants. Other factors include a lack of technology integration in the BSR process, nurses' numerous responsibilities, and competing priorities.

Nurse managers also face competing priorities that make it challenging to effectively audit BSR, resulting in inconsistent completion of the BSR process. Auditing BSR can be resource-intensive, and consistent monitoring is necessary to identify areas that need improvement or to celebrate successes. Some units train champions to audit BSR, which creates an additional cost or diverts staff from other productive activities. Becker et al. (2020) reported audit challenges, including a lack of champions, leadership support, and frequent auditing, only sustained BSR in six out of eleven units after fifteen months. The challenges with auditing BSR lead to poor feedback on compliance with BSR. Without constructive feedback, there is little incentive to adhere to best practices. Some staff may improve compliance only when being watched by their managers. This is challenging for managers to achieve because reports are often at 0700/1900, and there are multiple staff nurses to observe simultaneously completing BSR.

One challenge with auditing through observations is the Hawthorne effect, where individuals may exhibit the observed behavior when being watched, but compliance may decrease when they are not observed. The temporary completion of BSR, when observed, does not lead to sustained practice, and the safety, satisfaction, and quality benefits of BSR may be ephemeral. These challenges collectively contribute to difficulties sustaining and hardwiring BSR practices in hospitals.

Resistance to change from staff, coupled with inconsistent procedures and time constraints, often leads to a reversion to handoff practices being completed at the nurses' station, in hallways, or in offices away from the bedside. Resistance from nurses when introducing changes to clinical practice was observed in the selected project organization and is also highly reported in nursing literature. Carkiroglu et al. (2021) found that resistance to change was common in many healthcare settings and that nurses' attitudes towards change could be positively influenced when nurses were informed about change, took a democratic approach to implementing it, and were included in designing and implementing the change. Nurses' perception that BSR takes longer is a significant factor leading to resistance to change, and the lack of standardization leads to various BSR practices. The interconnected challenges highlight the need for a comprehensive strategy that addresses the barriers and leads to a culture that embraces the benefits of BSR, which include enhanced safety, satisfaction, and care quality.

Examining why implementing change is challenging for organizations and, even more so, how to sustain change is important for quality improvement projects. Bressen et al. (2019) conducted an umbrella review of nursing handoffs and their impact on patient safety, concluding that nursing handoff practices are complex and require a cultural shift, as well as strategies tailored to the specific context that meet the needs of both staff and patients. Dorvil (2018) concluded that nursing leaders who want to implement and sustain BSR must focus on several key indicators, including process and relationship management, mentoring, and having a well-planned and executed process. It is also essential to remain curious, open to feedback, and focused on making iterative improvements that drive continuous growth.

Although the selected organization has implemented BSR, it is done inconsistently, resulting in notable variations in the process, which makes it challenging to realize the benefits of

patient and nurse satisfaction and safety. The organization has witnessed issues with skin breakdown, intravenous (IV) catheter infiltrations, disconnected IV medications, incorrect dosages of medications, and changes in condition at shift change, leading to potential patient harm. Although nurses are expected to complete a full BSR, the process is not always completed due to assorted reasons. Some nurses prefer to complete the report with a similarity to the modified BSR or combine aspects of BSR with minimal standardization.

The organization has attempted to standardize the BSR process through an SBAR (Situation-Background-Assessment-Recommendation) handoff policy, which recommends that nurses follow an SBAR report and document who they received a report from. During orientation, nurses are trained to utilize a professional exchange report in the electronic medical record (EMR). However, few maintain this practice. The policy has recommendations from the Joint Commission and AHRQ. However, the standardized format is not based on the AHRQ checklist, nor on how this evidence-based practice can inform the organization about the best practices. The organization has also not spent much time understanding the nurses' reluctance to complete BSR consistently.

It is essential to understand why staff nurses do not consistently adhere to recommended safety practices related to handoffs, given the numerous reported benefits. Jaber et al. (2022) reported on the effects of BSR on promoting patient safety and the impact on nurse satisfaction, positive attitude towards work, collaboration, and teamwork. To enforce BSR, the organization may benefit from exploring alternative solutions, such as implementing a modified BSR that retains some of the benefits of BSR while addressing patients’ and nurses’ concerns about BSR.

The Doctor of Nursing Practice (DNP) Scholarly Project implemented a modified bedside report as an alternative to a full bedside report, taking into consideration its impact on staff

nurses' perception of patient safety and satisfaction, staff nurse satisfaction, and whether they completed the elements of a modified AHRQ BSR Checklist.

Clinical Question

The development of a compelling population, intervention, comparison, outcome, and time (PICOT) question helps find evidence to support the project. The PICOT for the DNP Scholarly Project was: **(P)** For nurses in an inpatient hospital unit (**I),** does using a standardized handoff process based on a modified version of the AHRQ Bedside Report Checklist (**C)** as compared to the current practice of bedside report **(O)** affect compliance and nurse's perception of satisfaction (**T)** over two months? The PICOT question was selected to determine if modified bedside report can be an effective alternative to meet the objectives of using a standardized handoff that works better for both nurses and patients during the shift-to-shift transitions of care.

American Association of Colleges of Nursing (AACN) DNP Essentials

DNP-trained nurses, as recognized by the American Association of Colleges of Nursing (AACN) Essentials (2021), are positioned to make significant contributions to the nursing profession. Their identified competencies, which include knowledge of nursing practice, person-centered care, population health, scholarship of the nursing discipline, quality and safety, interprofessional partnerships, systems-based practice, informatics and healthcare technologies, and personal, professional, and leadership development, equip them to become practice experts and apply evidence-based knowledge in complex healthcare systems.

The DNP Scholarly Project utilized various domains outlined by the AACN, particularly Domain Five (quality and safety), Domain Seven (systems-based practice), Domain Eight (informatics and healthcare technologies), and Domain Ten (personal, professional, and leadership development).

Domain Five aims to provide safe care that enhances quality, system effectiveness, and person-centered care, reduces errors, and encourages a safer work environment (AACN, 2021). DNP-trained nurses must become leaders in ensuring a safe, inclusive, and equitable workforce that promotes quality, safety, and improvement science.

Domain Seven is at the forefront of healthcare systems, focusing on developing innovative solutions that align with organizational values, healthcare costs, and changing management to reduce gaps that lead to patient harm (AACN, 2021). DNP-trained nurses must be able to implement quality improvement (QI) projects in complex healthcare systems to meet the quintuple aim that has expanded on the initial triple aim developed by the Institute for Healthcare Improvement (IHI). The triple aim endeavored to improve patient experience and population health while reducing healthcare costs. Clinician burnout, well-being, and advancing health equity were added to become the quintuple aim (Nundy et al., 2022). DNP-trained nurses are expected to become leaders in promoting these values.

Domain Eight focuses on informatics and healthcare technologies. Utilizing the EMR to help standardize processes may result in more consistent outcomes that promote safety. The EMR at the selected healthcare organization provides a professional exchange report that clinicians can use during the handoff process to review the patient's diagnosis, medical history, active orders, recent vital signs, labs, upcoming tests, and procedures. The AHRQ recommends that these items be reviewed during handoff and are included on its Bedside Report Checklist.

Domain Ten is instrumental for DNP-trained nurses as they develop their leadership skills. DNP professional nurses must develop their leadership skills through self-reflection, lifelong learning, and resilience to become change-agents who influence and promote advocacy (AACN, 2021). DNP-trained leaders should develop practical transformational leadership skills

by utilizing resources that foster growth and development and provide a roadmap for leading others.

DNP-trained nurses must comprehend how rapidly advancing technology is reshaping healthcare systems-based practice to ensure safe, high-quality care. DNP-trained leaders play a pivotal role in driving change within the healthcare system by developing and implementing organizational, state, and national policies (Sherrod & Goda, 2016). DNP-prepared leaders serve as catalysts for change within complex healthcare environments.

CHAPTER TWO: THEORETICAL FRAMEWORK

The DNP Scholarly Project applied a change management framework based on John Kotter's Eight Steps for Leading Change, which served as a foundational guide for modifying the handoff process. Changing an ingrained clinical practice, such as patient handoff, requires deliberate and structured change management. Kotter's model provides a strategic roadmap, emphasizing the importance of iterative learning, focused testing, and adaptability, which are crucial to achieving sustained quality improvement in clinical settings (Appendix C outlines how Kotter's steps were applied in the DNP Scholarly Project). The framework created a robust strategy for integrating a modified bedside report to enhance patient safety and quality of care.

Kotter's eight-step change management process includes the following: creating a sense of urgency; building a guiding coalition; developing a vision and strategy; communicating the change vision; empowering employees for broad-based action; enabling action by removing barriers; generating short-term wins; consolidating gains and producing more change; and anchoring new approaches in the culture (Kotter, 2012). Each of Kotter's steps played a vital role in implementing the project.

Figure 1: *Kotter's Eight Accelerators for Change*



Creating a sense of urgency was achieved by highlighting safety concerns and inconsistencies in current handoff practices, which helped mobilize stakeholders and created momentum for change. The project's education and messaging emphasized the importance of having effective shift-to-shift care transitions to prevent medical errors, misunderstandings of treatment plans, and failing to share critical information. The project's benefits were emphasized, including how nurses could benefit from and participate in the project's interventions.

A guiding coalition comprising the pilot unit's shared leadership team, registered nurses, unit management, and hospital administration played a crucial role in the project. Their diverse roles and collective focus on promoting cooperation, feedback, and accountability supported the coalition.

A pivotal step in the project was developing a vision and strategy to improve communication, safety, and satisfaction through a standardized handoff process with clearly defined goals and measurable outcomes. This vision, which outlined the project's objectives and needs, inspired others to get involved and fostered a sense of commitment and motivation.

Communicating the change vision was an ongoing effort that included a PowerPoint presentation, emails, daily huddles, visual reminders, and one-on-one coaching to reinforce the purpose and benefits of the change. Communicating the vision through multiple modes of communication was imperative, as people learn by various methods. Some people are more visual learners and may benefit from having a visual aid, whereas others may learn more effectively by hearing the huddle message. Active listening and addressing concerns promoted two-way communication, helping to elicit people's feelings about the change.

Promoting broad-based action included empowering staff to become active members by being transparent and inclusive. Allowing employees to provide feedback, express concerns, and

provide support helped build confidence with the new process. Removing barriers involved clarifying roles, providing necessary tools, and ensuring that workflow changes were compatible with existing shift structures.

Incorporating Kotter's model, the DNP Scholarly Project leader emphasized the importance of finding short-term wins, which was accomplished by showing gratitude for improvement and celebrating milestones. This is often an overlooked aspect of project management because people become so focused on the data and producing results that they forget to acknowledge and appreciate progress. Recognizing achievements during one-on-one coaching, meetings, and huddles helped maintain motivation and commitment throughout the project. Building in celebrations at key milestones reinforced the value of hard work, fostered a sense of community, and shared purpose among team members. A pizza party was held at the end of the first month to recognize staff's contributions to the change management process.

The integration of iterative cycles, continuous feedback, and a quick response code enabled staff to provide feedback at any time during the project (See Appendix D), thereby enhancing the implementation process and consolidating gains. The leader facilitated continuous learning and improvement by adopting an iterative approach to learning and improvement. Each iteration allowed the team to assess the effectiveness of changes, identify areas for refinement, and adjust strategies based on feedback and data, further strengthening teamwork and collaboration.

DNP-prepared nurses are dedicated to enhancing healthcare systems, and strong leadership skills are important to realizing this objective. Transformational leadership proved to be a helpful strategy for implementing the DNP Scholarly Project. Transformational leadership requires emotional intelligence, enthusiasm, collaboration, and communication skills to inspire,

coach, and mentor others (Armstrong & Sables-Baus, 2020). Demonstrating these competencies enables leaders to transform their healthcare environments into high-reliability organizations that cultivate a safety culture promoting trust, transparency, engagement, and zero harm.

The DNP Scholarly Project leader modeled clarity, kindness, and hope, aligning with Kotter's recommendations to balance head and heart in leadership. The project leader cultivated a climate where people felt free to ask questions, seek feedback, and provided reassurance. Rolling out a new project can be confusing, and people may ask questions and absorb the information at different rates. It is essential that they feel comfortable asking questions and making mistakes, allowing them to learn throughout the process. Transformational leaders should practice patience and offer a hopeful vision for the future, acknowledging the uncertainties that often accompany change.

Ethics and interdisciplinary collaboration were used to implement the DNP Scholarly Project. Clear communication and a structured implementation plan that recognized the contributions of stakeholders were vital to the successful implementation. The DNP Scholarly Project leader adhered to the Code of Ethics for Nurses, specifically Provision Six, to maintain an ethical work environment that fosters safe and high-quality healthcare (Fowler, 2015). The DNP Scholarly Project fostered a respectful and collegial work environment that valued and respected participants. As the change becomes ingrained in the organizational culture, it will be essential to promote ethics and collaboration. It will also be important to continue rewarding individuals and teams who maintain the change. Redefining training, ensuring ongoing competency, and encouraging storytelling will be necessary to achieve Kotter's eighth step, which focuses on ingraining the change in the organization's culture. The literature review

focused on identifying a sustainable, patient-centered approach to delivering safe care transitions during shift changes.

CHAPTER THREE: REVIEW OF LITERATURE

The Cumulative Index to Nursing and Allied Health Literature (CINAHL), Public/Publisher Medline (PubMed), Excerpta Medica Database (EMBASE), Google Scholar, and Psychological Information Database (PsycINFO) were searched to find support for the DNP Scholarly Project. The titles were searched, and Booleans were added, including AND, OR, and NOT. The databases were searched for all relevant studies meeting the terms of the search terms. There appeared to be two waves of articles written between 2006 and 2016 and from 2016 to the present on the topic. The articles were narrowed to include only academic journals written in English between 2016 and 2025. The titles and keywords were scanned for additional search terms. The ancestry method, proximity search, and relevant articles search helped find additional articles related to the topic.

Multiple searches were conducted in CINAHL, PsycINFO, PubMed, Embase, and Google Scholar. The most effective search terms were nursing AND bedside report or bedside handoff. The terms modified bedside report/handoff, blended bedside report/handoff, and partial bedside report/handoff resulted in two or fewer results. Other key terms included shift-to-shift transition of care, shift-to-shift handoff/report, bedside handover, and bedside transition of care. The same articles appeared in various databases. Articles were retrieved from quality, administration, and clinical-care journals as the basis for the literature review.

Melnyk and Fineout-Overhold (2023) created a four-phase rapid critical appraisal methodology for evaluating studies. This method was used to evaluate the evidence and quickly assess which studies support the project by evaluating the study, synthesizing the body of evidence, and examining the recommendations from the study. The selected articles were

examined regarding validity, reliability, applicability to the proposed project, and practice change recommendations. Articles that best answered the PICOT question were selected, and a Table of Evidence was created.

During the literature analysis, four themes emerged that support the completion of the proposed project to improve compliance and safety in the nurse handoff process. These themes served as the foundation for completing the proposed DNP Scholarly Project.

Standardized Bedside Handoff/Report

The first theme that was identified is the standardized bedside handoff/report. Forde et al. (2019) described bedside handover as the transfer of responsibility and patient accountability between nurses during shift change. The authors found that BSH improved effective communication, promoted patient participation, and reduced risk. The authors recommended that this practice be embedded in the organizational culture by making it a strategic initiative and understanding the handover structure, process, and content to sustain bedside handoff. McAllen et al. (2018) defined BSR as accurate and timely communication between nurses and patients. The authors examined the effects of BSR on patient safety, patient satisfaction, and nurse satisfaction using an ISBARQ (Introduction, Situation, Background, Assessment, Recommendation Questions) tool. The authors reported a compliance rate of 94%, a 24% decrease in falls, and an improvement in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, utilizing a PDSA (Plan-Do-Study-Act) framework, Kotter's Eight-Step Process for Change, and an auditing tool for staff adherence.

Becker et al. (2020) completed a BSR quality improvement (QI) project after noting that BSR was not standardized and sustained. The authors utilized a standardized shift tool and adopted a patient education brochure from the Agency for Healthcare Research and Quality

(AHRQ), which was placed in the patient's admission folder. The authors found an increase in patient awareness of BSR from 43% to 74%, a 15-month post-implementation BSR compliance rate of 82%, and improved HCAHPS scores in nurse listening. The authors reported issues with resistance to change, inconsistencies in reports, auditing challenges, and difficulties with reinforcement as barriers. The unit champions completed the audits every other day on all shifts. Not all units completed audits and submitted data. The results highlighted the time-consuming, labor-intensive, and inconsistent nature of the current process of completing BSR audits involving observation. The authors emphasized that completing a safety check to verify alarms, lines, and tubes, observing the patient's room for potential safety risks, and auditing, measuring, and disseminating results were crucial for standardizing the practice.

Numerous QI initiatives have examined ways to enhance compliance with BSR. Fucik (2019) developed a standardized tool for BSR upon recognizing the variability in the handoff process between staff nurses, including inconsistencies in information sharing inside or outside the room, including patients and families, and inconsistent completion of safety checks by staff nurses. Pino et al. (2019) conducted PDSA cycles, developed a standardized handoff tool, and provided training to staff on completing a standardized BSR, resulting in improved compliance.

Malfait et al. (2018) completed a multicenter observational study to examine a standardized BSH using an ISBARR(Introduction-Situation-Background-Assessment-Recommendation-Readback) tool, determining that high compliance rates could be achieved with a minimum amount of nurse training. The training consisted of a slideshow presentation, an informational brochure, and a small-group simulation, totaling approximately eight hours in duration. Key takeaways were that in 30% of observations, nurses decided not to complete bedside handover, and the patient was not actively participating in about one-third of all

observations. This led to the conclusion that even if BSH is completed, it is not always patient-centric, and patients are often excluded from the process. They also noted five frequently omitted items, including identifying the patient, introducing the oncoming nurse, adherence to hand hygiene, asking patients if they had any questions or anything to add, and showing patients how to use the call light.

Desmedt et al. (2020) completed a systematic review of clinical handoffs in healthcare. The review examined various tools used to complete handoffs, including checklists, mnemonics, and different forms, and found no single tool that was most effective for handoffs. The authors found that poor handoffs can lead to potential hazards and should be avoided by providing ongoing feedback and training to staff nurses to improve handoffs.

Facilitators of Bedside Report—Patient and Nurse Satisfaction

The second theme that emerged from the literature review was the facilitators of bedside reports, specifically patient and nurse satisfaction. Research by White-Trevino and Dearmon (2018) in an emergency department revealed that 58% of patients actively participated in BSR by sharing information or asking questions, with 92% expressing satisfaction with the process. McAllen et al. (2018) examined the Press Ganey scores and found an average score increase from 87.7% to 91.6% with the implementation of BSR. The increased scores were not statistically significant in all units. Scheidenhelm and Reitz (2017) found that BSR is an evidence-based practice that increases patient involvement in their care and improves patient satisfaction. The authors used a change management strategy and standardized approach to BSR to increase nurse compliance with the process, which led to higher patient satisfaction scores.

Brown-Deveaux et al. (2022) focused on creating a standardized BSR process to improve communication, guide practice, reduce falls, and improve HCAHPS scores. The goal was to

apply high-reliability organization (HRO) principles to minimize variability in the BSR process, complete nurse education, and utilize simulation to demonstrate BSR techniques. The pre/post survey results of nurse preference to complete BSR increased from 66% to 87%, and 85% of nurses agreed or strongly agreed that BSR was an efficient use of the nurse's time. The authors also found that the intervention decreased falls by 60% in one unit and increased communication domain HCAHPS scores by 22%. The authors recommended streamlining the BSR, establishing unit-specific champions, securing leadership oversight, and maintaining continuous communication. The findings underscore the positive impact of BSR on patient engagement and satisfaction, highlighting the project's importance.

Barriers to Bedside Report

The third theme that the review of literature discovered was the barriers to BSR. Bressan et al. (2019) conducted a meta-synthesis of patients' experiences with BSR, identifying some of the benefits and drawbacks of BSR. Patients enjoyed receiving information about their care and participating in the decision-making process when involved in BSR. Patients also recognized the importance of connecting with nurses and appreciated the safety benefits that BSR offers. The results were that some patients did not want to participate in BSR, some wanted to be passive participants rather than active, and some patients reported feeling frustrated by being woken up repeatedly to hear their stories. The other drawbacks reported by patients included nurses using professional jargon and concerns about confidentiality when patients were not in private rooms or when visitors were present. The presence of BSR was reported to cause anxiety and dissatisfaction with the process when patients did not feel supported by nurses.

The evidence in the literature supports the positive outcomes of BSR; however, there are barriers to implementing and sustaining standardized, consistent BSR. Several studies identified

the challenges with sustaining bedside reports. Elgin and Poston (2019) found that compliance with shift report practices was varied and inconsistent, affecting patients' access to high-quality, safe care. The authors found that a nurse's comfort and self-efficacy with the reporting process were barriers that affected compliance. The AHRQ Bedside Shift Handbook and simulation learning experience were utilized to improve compliance with BSR. The AHRQ (2013) provides guidelines that allow organizations to determine which elements of BSR are essential for enhancing consistency, standardization, and safety in BSR.

O'Donnell et al. (2023) found that the key to sustaining a BSR process is for nurse leaders to develop a coaching method to educate and validate nurses. The authors suggested that leaders must find a way to mandate consistent performance and utilize a structured process to provide coaching. The study, conducted in 16 hospitals, resulted in increased HCAHPS scores and Value-Based Purchasing (VBP) point accumulation, both of which are crucial to the hospital's reputation and the delivery of high-quality care. The study stands out because it employed a multi-hospital approach, a method not commonly found in other QI studies, which lends credence to the applicability of the findings.

Clari et al. (2021) completed a systematic review and analysis of barriers and facilitators of BSR to provide recommendations on implementing an effective bedside nursing handover. The article emphasizes the significance of handoffs in ensuring patient safety and quality, highlighting that handoffs occur multiple times per day and acknowledging conflicting evidence on the long-term effectiveness of BSR. The authors described that bedside reports could lead to anxiety, stress, and feelings of inadequacy in patients. Patients may lack knowledge of medical jargon and struggle to understand the complexity of the information being discussed, which can hinder their active participation in BSR. The authors also cited perceived barriers by staff nurses

that BSR adds more time to report, may violate a patient's confidentiality when visitors are present or in a double room, and often leads to distractions and interruptions.

Scrhrim et al. (2018) acknowledged that nurses often resist BSR implementation, leading to considerable effort to implement and maintain it. They also recognized that patients reported disadvantages, including hearing the same report over several shifts. The authors used a 15-item Nursing Assessment of Shift Report survey to evaluate nurses' perceptions of BSR, as well as five questions to assess patient satisfaction with nursing care.

Positive perceptions of BSR among nurses included maintaining professionalism and accountability, promoting patient safety, enhancing communication and family involvement, and fostering therapeutic relationships between patients and their families. Other benefits included the incoming nurse being able to identify problems before the outgoing nurse leaves, and promote safety by performing safety checks and looking for safety hazards.

Scrhim et al. (2018) also found disadvantages to bedside report, including increased time to conduct report due to patient and family interruptions, repetition of information, disruption of the patient's sleep, and confidentiality issues when a patient had visitors or was in a double room. They received comments from nurses that BSR should not be a mandatory practice but left to the nurses discretion; that seeing the patient with the off going nurse was helpful, but report should be outside the room; and that there should be a modified shift report for some situations where the bedside report should include an introduction and safety check of drips and safety equipment.

Tobiano et al. (2017) recognized that, despite international recommendations for BSH to promote patient safety, there is variation in the process, and that understanding nurses' perceived barriers is key to understanding BSH. The most common barrier was confidentiality, as well as

the potential to reveal sensitive information to patients. This concern often led to nurses passing sensitive information away from the patient outside the room. Nurses also identified communication interruptions from patients and families that disrupted the efficient flow of communication. The nurses reported being distracted by questions asked by patients or their families and sharing unrelated information, which led to increased report times. The nurses in the study also reported that patient conditions and emotional states could interfere with BSH, including cognitive deficits, anxiety, upset patients, and patients who felt uncomfortable. There were also nursing barriers, including some nurses lacking the confidence to complete BSH, particularly when dealing with sensitive information. Nurses expressed privacy concerns and interruptions as their most significant challenges with the BSH, resulting in a mixed preference for completing it. The authors suggested that nurse reflections may be helpful for nurses to evaluate their approach towards BSH, improve compliance, and enhance nurses' value towards the patient-centered practice.

Modified/Blended/Partial Bedside Report

The fourth theme identified, relevant to the DNP Scholarly Project, is the modified, blended, or partial bedside report. Emerging evidence suggests that a modified or partial bedside report may be a potential solution to address some of the barriers and dissatisfiers expressed by nurses and patients. Jimerson et al. (2020) examined why BSR adoption rates remain low in organizations and recommended a modified approach to BSR. The approach addresses the barriers of time constraints, interruptions, distractions, and confidentiality issues that nurses often report. Staff nurses preferred to hand over sensitive information away from the bedside; however, they recognized the importance of including patients in BSRs and allowing patients to speak up during these reports (Whitty et al., 2016). Jimerson et al. (2020) found that the modified

BSR approach enabled nurses to discuss critical information during handoffs without interruptions. The approach increased patient satisfaction and encouraged participation in BSR, aligning with AHRQ and Joint Commission recommendations to provide a safe handoff that involves the patient and allows them to ask questions.

Grimshaw et al. (2020) employed a qualitative approach to understanding the challenges associated with BSR and the reasons for the continued inconsistency and lack of standardization despite many years of practice. The authors identified nurses' concerns about the time factor of BSR, challenges in communicating sensitive information, and resistance to change. The article discussed the benefits of BSR, including increased patient satisfaction, the advantages of conducting a visual inspection of the patient and environment during BSR, and the fact that patients gain a better understanding of their care. The authors concluded that BSH can be safely divided into two sections, with one part conducted outside the patient's room and the other part conducted inside the patient's room, to meet the satisfaction levels of both nurses and patients. The standardized modified approach that considers this factor may improve compliance with the process, leading to safer outcomes and higher satisfaction.

Webster et al. (2024) focused on standardizing a communication tool based on the acronym COAST (code status, oxygen, access, safety, and tubes/drains) during blended bedside handoffs. They focused on these safety aspects of care based on their internal and external evidence of potential safety events. Baseline data from 30 observations of BSR showed that the COAST elements were only followed in 5% of the reports, but this increased to 60% after implementing education in staff meetings and emails during a nine-month pilot. The study also demonstrated that implementing a change management approach to introduce a blended BSR,

with a focus on safety elements, increased the adoption of modified BSR and improved safety outcomes.

Synthesis of Literature

The literature review encompasses a diverse range of topics related to bedside reports, with several key themes emerging. Most of these studies were conducted as single-center QI projects. The literature review revealed a scarcity of longitudinal or randomized controlled studies, particularly those examining patients' experiences over time. The literature is limited in terms of providing generalizable results. However, it offers valuable insights into the interventions and outcomes used in those studies, which guided the development of the DNP Scholarly Project.

The studies support the need for a standardized BSR process that staff nurses can follow (Fucik, 2019; Pino et al., 2019; Brown-Deveaux, 2022; The Joint Commission, 2017; AHRQ, 2013). A standardized approach to BSR clarifies the guidelines and expectations for staff nurses. Studies found that this may improve compliance with BSR (Malfait et al., 2018; Martini & Resek, 2021). The standardized approach to BSR also provides patients and families with a straightforward method for improving awareness and participation in BSR. One study utilized the AHRQ Bedside Report Checklist (Elgin & Poston, 2019), whereas others developed their own tools (Wollenhaup et al., 2017; Martini & Resek, 2021; Faloon et al., 2018). Further studies could be conducted to evaluate the most effective approaches or tools for achieving better patient outcomes.

Patient experience and its impact on HCAHPS scores have been discussed in several studies, which have found that patients appreciate being included in BSR (White-Trevino & Dearmon, 2018; McAllen et al., 2018; Scheidenhelm & Reitz, 2017; Brown-Deveaux et al.,

2020). The increased patient satisfaction was related to communication, such as nursing introductions, reviewing care plans, and asking patients if they had any questions. Many of the safety benefits were related to the visualization of the patient, checking for fall bundle elements, and performing a focused assessment and environmental scan.

Both patients and nurses reported apparent drawbacks and barriers to BSR. Nurses often reported time constraints, interruptions, and distractions as the main concerns about BSR. They also reported privacy concerns, patient sleeping, and not wanting to discuss sensitive information at the bedside (Tobiano et al., 2019; Faloon, 2018; Malfait et al., 2019; Oxelmark et al., 2020). Bedside reports are not without pitfalls and barriers (Bressan et al., 2019; Clari et al., 2021; Jimerson et al., 2020; Grimshaw et al., 2020). Patients complain of being woken up to hear the same story; many do not know how to participate or understand the process, and do not understand medical jargon. Patients also have privacy concerns, feel too tired, or have anxiety about participation. Many of the studies reviewed acknowledged the concerns of both patients and staff nurses and provided evidence for a modified BSR.

The literature supported a modified bedside report (Becker et al., 2020; O'Donnell et al., 2023). The modified approach benefits from the fact that communication and safety checks are still completed at the bedside, but the report is given at the nurses' stations in front of the computer, where the off-going and oncoming staff nurses can review labs, medications, and orders without having to explain every detail to patients (Grimshaw et al., 2020; Jimmerson et al., 2020; Martini & Resek, 2021). The modified approach also considers the negative feedback received from patients and nurses related to BSR. The modified approach seems more natural to staff nurses because it allows handoffs away from the bedside, where nurses can speak freely using a situation-background-assessment-recommendation (SBAR) handoff report.

Gaps in Literature

The gaps in the literature do exist and will be considered in the proposed DNP Scholarly Project. The full bedside report was the primary intervention in most studies. The emerging evidence supports that modified bedside reports may add safety and patient satisfaction benefits. Randomized controlled research studies should be conducted to provide a more reliable and valid method to support modified versus full BSR. Multicenter, longitudinal studies could also fill in gaps in the literature on this topic.

The DNP Scholarly Project's interventions are supported by the process of combining the evidence that supports implementing a modified BSR to promote patient safety and quality. The methodology section will explain the interventions and how they were implemented and evaluated.

CHAPTER FOUR: METHODS

Project Design

The Doctor of Nursing Practice (DNP) Scholarly Project used a mixed-methods quality improvement (QI) design. Quantitative data were collected to understand the relationships between variables and determine if the changes were statistically significant. Qualitative data allowed participants to provide feedback during the iterative cycles to elicit input and understand recommendations.

Ethical Considerations

The University of California, Los Angeles (UCLA) Institutional Review Board (IRB) reviewed the DNP Scholarly Project. The IRB determined that a formal review was unnecessary because the project did not meet the definition of human subject research. The UCLA IRB issued a letter stating the project did not require IRB review (See Appendix E). Project participants were treated with respect and dignity and did not experience any hardships due to the project's interventions.

Setting

The project was completed at a county hospital in northern California, which was part of a four-hospital system. The selected pilot unit was a 22-bed intensive care unit (ICU). The unit employs approximately 100 nurses, a nurse manager, a staff developer, and three assistant nurse managers who helped select project champions and assisted with the required education.

Sampling

Members of the ICU Shared Leadership committee were recruited using convenience sampling. The champions were resources for guiding staff on modified bedside handoff (BSH), educating unit nurses about the project's interventions, and promoting feedback.

The inclusion criteria included nursing staff who voluntarily agreed to participate in the project, participated in the iterative cycles, gave open feedback, and were committed to improving BSH. The participants were informed about the time commitment and expectations, allowing them to make an informed decision about participating.

The project was introduced at the ICU Shared Leadership monthly meeting. Emails, huddle messages, and the unit management were instrumental in encouraging people to participate. Strategies to enhance interest and commitment included establishing a clear vision and benefits, practical training, and clear communication channels. Small tokens of appreciation, including food, small denomination gift cards, and badge reels, were given to unit participants and paid for by the DNP student. Building a rapport with the volunteers was essential for fostering a sense of ownership and commitment to the project. By implementing these strategies, the project cultivated an enthusiastic and committed group of participants based on change management principles. Potential feasibility issues were identified during the project's planning, including problems with retention due to sick calls, vacations, low incentives to participate, and attrition. To minimize overtime and paid educational time, participants completed the project primarily during their work hours, which were often constrained by patient care duties. The unit's staff nurses were busy and had many competing priorities.

Implementation & Data Collection

The DNP Scholarly Project consisted of several primary interventions, each broken into separate phases. This included standardizing the handoff process, educating staff nurses about it, implementing patient education materials, and drafting an organizational policy that reflected the modified BSH, aligning with the Joint Commission and the Agency for Healthcare Research and Quality (AHRQ) recommendations for a standardized handoff process.

Intervention One—Implementation of Modified Bedside Handoff

The DNP Scholarly Project addressed standardization of the handoff process using a modified version of the AHRQ that recognized modified BSH. The modified, partial, or blended BSH, where part of the report was given outside the patient's room, and a portion was conducted inside the patient's room, incorporated the evidence from the literature review. The approach allowed nurses to exchange information away from the patient, where they could speak freely, use medical jargon, and review orders, systems, and pending items in an environment free from distractions and interruptions. The organization utilized the Situation, Background, Assessment, and Recommendations (SBAR) report and a professional exchange report summary in the electronic medical record (EMR). The second part of the handoff was completed in the patients' rooms, where the outgoing nurse introduced the incoming nurse and conducted a patient safety check and an environmental safety scan. The patient was included in discussing the care plan and goals for the day, and the patient was allowed to express concerns or ask questions. Patients were allowed to invite their families to participate. Utilizing a modified BSH standardized handoff process sets the expectation for staff nurses to follow during handoff at the transition of care. The pilot unit helped shape the process that can be utilized to implement BSH in other inpatient units.

Intervention Number Two—Patient Education about the BSH Process

Patients were educated about modified BSH and invited to participate as an additional intervention. Patients received a brochure, and nurses discussed the modified BSH process with patients and their families during admission to the intensive care unit. The AHRQ trifold Nurse Bedside Shift Report pamphlet was customized to the healthcare organization. The brochure explains the handoff process, how patients can participate, and covers what to expect, inviting patients to participate (Appendix F).

Posters were placed on the patient's room walls that visually displayed the BSH process. The poster was used to educate patients about the BSH process and invite them to participate. The posters included information on what patients can expect, the handoff times, and the safety benefits of completing the handoff at the bedside. The posters were designed with clear graphics and concise language. These educational posters and brochures were integrated into patient education to enhance patient awareness, promote participation, and improve the quality and safety of care delivered in the unit. The posters also made the handoff process clear for staff nurses and served as a reminder when needed (See Appendix G).

Intervention Number Three—Nursing Education

A simple nursing education plan was created to inform staff nurses about the project interventions. It consisted of creating a PowerPoint slide presentation (See Appendix H) that utilized the steps of Kotter's change management, including creating a sense of urgency, forming a guiding coalition, and setting the vision. The PowerPoint presentation was emailed to staff, was included in the daily huddle, and posted on the Shared Leadership communication board. The information was also discussed during various meetings.

Intervention Number Four—Policy Update and Project Expansion

The final step of the project was to submit an updated handoff policy to reflect the process updates, including the use of a modified BSH based on a revised version of the AHRQ bedside report checklist (See Appendix I). The policy reinforces the expectations and process for completing BSH, allowing the interventions to be expanded to additional units throughout the organization. The DNP Scholarly Project results are expected to be sustained utilizing Step Eight of Kotter's Eight-Step Model to sustain change, boosting safer, high-quality care.

Data Collection Measures

The DNP Scholarly Project was conducted to improve organizational processes and workflows, which necessitated the development of effective data collection instruments. Baseline data were collected and compared to post-intervention data to see if there were measurable changes after implementing the interventions. The goal of the DNP Scholarly Project was to implement a standardized handoff process. A triangulation data collection approach, incorporating surveys, observations, and interviews, was employed to enhance the rigor and validation of the QI project.

Thirty pre-implementation BSH observations were completed to understand the handoff process and collect baseline data. The observations were used to determine whether BSH was completed before the interventions and to identify any variations in the process. The DNP project leader trained the unit manager and staff developer using the modified AHRQ Bedside handoff checklist (See Appendix J) and observed the completion of two observations to improve interrater reliability. The observers indicated whether the nurses completed the items on the checklist and whether they were done at the bedside or outside the patient's room.

Once the observers were trained and the initial baseline data were collected, the observers completed ten weekly observations and coached nurses on BSH expectations. Feedback from the observations was discussed to gain a deeper understanding of the process and make recommendations for improvement. Thirty post-study observations were conducted during the last week of the study and compared to baseline data.

Staff nurses completed an anonymous questionnaire to capture pre- and post-data for the standardization of the BSH process. The DNP Project leader asked the staff nurses to complete the Survey Monkey questionnaire using a quick response (QR) code. Survey participants were given small tokens of appreciation upon submitting their results (See Appendix K). Staff nurses who completed the survey were checked off using a staff roster. This allowed the staff to submit an anonymous response to the questionnaire while also ensuring that the same pre- and post-populations were sampled and that the survey completion goal of 35 surveys was achieved. The thirty-five staff members completed the same pre/post survey, which included 38 questions, including one demographic question related to years practicing as a nurse, two open-ended questions, and thirty-five questions gauging the nurses' opinion about modified BSH versus full BSH (See Appendix L).

The same pre- and post-questions were asked in the survey, including questions about the standardized approach to BSH, feedback on modified BSH, and which style was preferred. The questionnaire was piloted with five nurses to establish content validity before distribution. Staff nurses were asked to complete the pre-survey during the two weeks before the project's implementation. The post-questionnaire was available for two weeks after the end of the data collection period. One major drawback of self-reported questionnaires is that participants may inadvertently or intentionally provide misinformation, which can alter the results and make it

challenging to ascertain the validity of the results. The results were analyzed and compared as described in the results section.

During the project, the Kotter change management framework and iterative cycles enhanced the process by providing a guide for understanding the challenges, barriers, and opportunities for improvement in the DNP Scholarly Project. Iterations with the Shared Leadership Committee were utilized to gather feedback, identify learning opportunities, and implement real-time improvements, thereby promoting the modified BSH in the QI project.

Plan for Analysis

Analyzing data obtained during the DNP Scholarly Project was instrumental in understanding the findings and making recommendations. SurveyMonkey, a password-protected program, was used to collect and analyze questionnaire data. Observation data were collected using a paper AHRQ Bedside Checklist audit tool. The audit tool was safeguarded in a locked drawer and scanned to email for backup. The information from the audit tool was entered into a password-protected Excel spreadsheet for electronic organization and safekeeping. Excel and SurveyMonkey were used to create charts and graphs of the data.

BSH observations were another method of collecting baseline and post-implementation data. The goal was to obtain thirty baseline and post-observations on the unit. The data was analyzed using the percentage rates of BSH items completed. Graphs were constructed and presented in the results section.

One potential concern with using observations as a data source is that people may alter their behavior when being watched due to the Hawthorne effect. Observations may be biased, and human factors can influence observers, such as fatigue or distraction. The collected data

were used to help understand the BSR process before and after implementation and were used during the iterative cycles to facilitate improvement.

Staff nurses provided quantitative and qualitative data by taking a questionnaire and participating in focus groups, which provided qualitative feedback. The qualitative data were coded into themes and reported in a table format. The survey data were analyzed using independent t-tests and chi-square statistics. The results section presents the data from the survey, observations, and qualitative themes.

CHAPTER FIVE: RESULTS

The Doctor of Nursing Practice (DNP) Scholarly Project employed multiple data collection methods to evaluate the implementation and standardization of a modified bedside handoff process, aiming to enhance communication, patient safety, patient satisfaction, and nurse satisfaction. A triangulated approach, incorporating surveys, direct observations, and qualitative feedback, was employed to gain a deeper understanding of the problem and evaluate potential solutions. Baseline data were gathered prior to implementation and compared with post-intervention data to determine whether measurable improvements occurred. This section presents the findings from each data collection method, highlighting staff perceptions and observations.

Observations

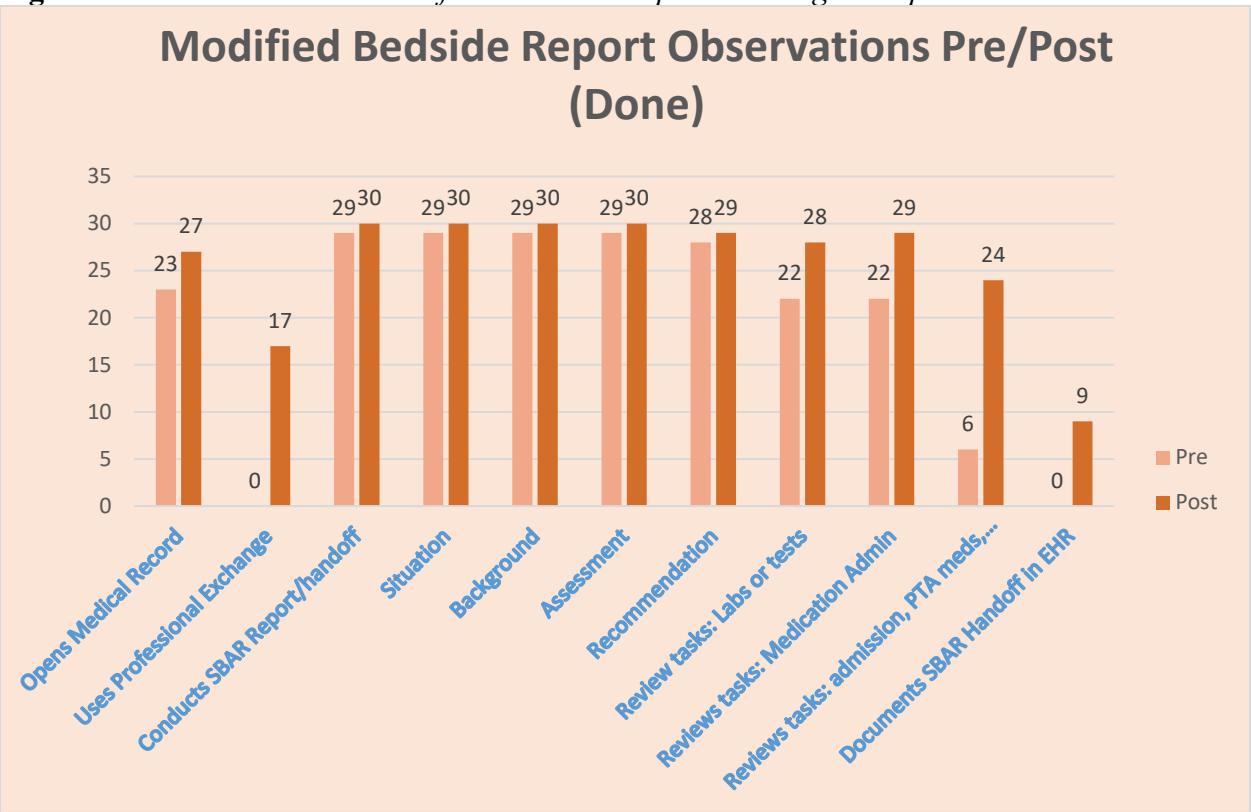
The pre-intervention data showed that staff nurses participating in the quality improvement (QI) project did not consistently use standardized approaches to report or hand off. The full bedside report (BSR) was practiced inconsistently. The observations showed that few nurses completed all the recommended Agency for Healthcare Research and Quality (AHRQ) checklist items. Figure 2 shows the completed pre- and post-items on the modified bedside observation checklist, which includes items that can be completed outside of the room. Thirty pre-observations were compared to thirty post-observations.

The staff nurses were observed opening medical records during handoffs 23 times prior to implementation, and this number increased to 27 after implementation. The organization trains nurses during new employee orientation to use a professional exchange report for handoffs that are included in the electronic medical record (EMR). Although the AHRQ does not specify this, it was added to the checklist to comply with the organization's current policy. Prior to the

intervention, no nurses were observed using the report, whereas 17 were observed during the post-phase. Completing the SBAR report was consistently completed pre/post, including conducting the SBAR handoff (29 pre, 30 post), Situation (29 pre,30 post), Background (29 pre, 30 post), and Recommendation (28 pre, 29 post).

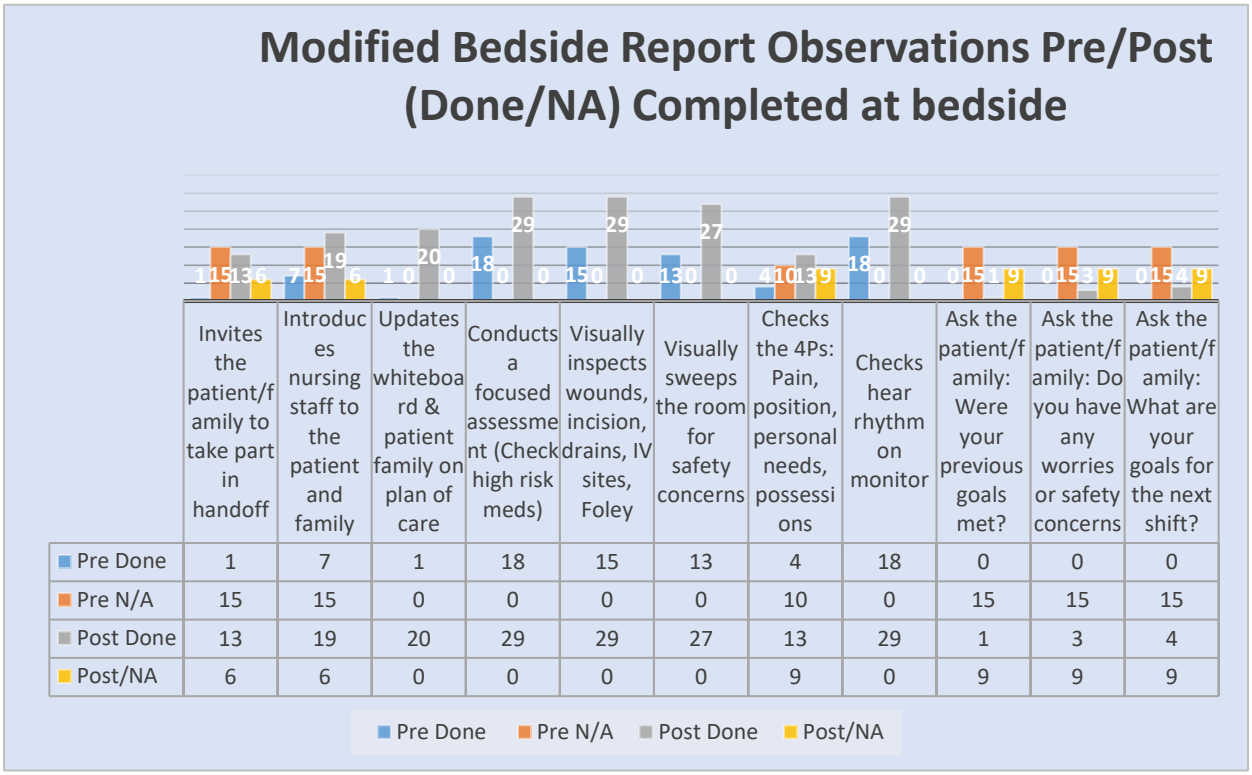
The AHRQ recommends that nurses review important tasks during handoffs, including recently completed or pending laboratory tests and medications, as well as other relevant details. During the pre-observations, laboratory tests were reviewed in 22 out of the 30 observations, and this number increased to 28 in the post-observations. The nurses discussed crucial medications that were administered or currently being administered, such as intravenous drips, improving from 22 to 29. Other items added to the checklist included reviewing tasks such as admission documentation, prior to admission medications, restraints, surgical and dialysis checklists, and chlorhexidine baths. These items are either commonly missed or not charted, and reviewing them during handoff may result in fewer missed items. Reviewing these tasks increased from six to 24 in the post-observations, indicating that nurses devoted more attention to handing off these important items. It is prudent to note that these items were not separated, resulting in a single line for all items, which may compromise the accuracy of the results. Staff nurses were given credit for discussing at least one of these items—very few discussed all items in this category. The organization's current policy also states that nurses should document handoffs in the EMR, including the name of the nurse who gave the report and the name of the nurse who received it. This item increased from zero to nine.

Figure 2: *Pre/Post observations of items to be completed during the report*



The other section of the modified bedside report observation checklist included items that were recommended to be completed inside the patient's room at the bedside and are listed in Figure 3. Pre- and post-observations were compared. Items in this section were scored if they were completed and if they did not apply. For example, some patients were intubated, sleeping, or sedated and therefore unable to fully participate, which was documented as 'not applicable'. Sometimes, family members were at the bedside who were still able to participate, even when the patients were unable to do so.

Figure 3: *Observations Pre/Post completed inside the patient's room*



	Invites the patient/family to take part in handoff	Introduces nursing staff to the patient and family	Updates the whiteboard & patient family on plan of care	Conducts a focused assessment (Check high risk meds)	Visually inspects wounds, incision, drains, IV sites, Foley	Visually sweeps the room for safety concerns	Checks the 4Ps: Pain, position, personal needs, possessions	Checks hear rhythm on monitor	Ask the patient/family: Were your previous goals met?	Ask the patient/family: Do you have any worries or safety concerns	Ask the patient/family: What are your goals for the next shift?
Pre Done	1	7	1	18	15	13	4	18	0	0	0
Pre N/A	15	15	0	0	0	0	10	0	15	15	15
Post Done	13	19	20	29	29	27	13	29	1	3	4
Post/NA	6	6	0	0	0	0	9	0	9	9	9

Pre- and post-observations were compared. The staff nurses were infrequently observed completing the AHRQ-suggested patient satisfaction items, such as updating the whiteboard, asking patients and their families about their concerns and goals, and following up to ensure these concerns and goals were met.

The AHRQ encouraged nurses to invite patients and their families to participate in the report process, which occurred only once during the pre-observation period and 13 times post-observation. Fifteen patients were unable to participate in the pre- and six in the post-BSR observations. Observations of the introduction of the oncoming nurse to the patient were conducted seven times pre-intervention and 19 times post-intervention, with 15 pre-observations and six post-observations unable to participate. Updating the whiteboards, which are important

for communicating who is caring for the patient and displaying pertinent plan of care information, was completed once during the pre- and post-20.

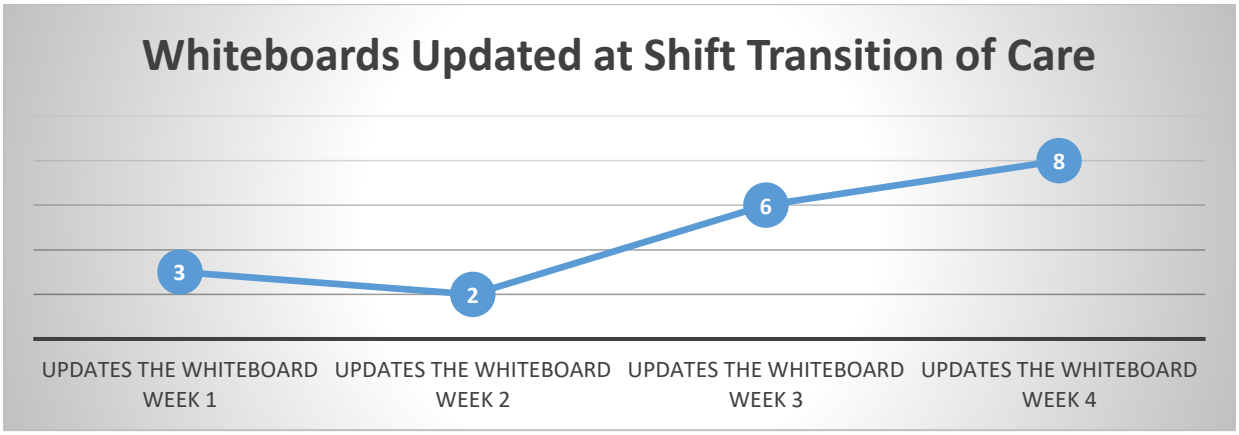
Several vital items contribute to patient safety, including conducting a focused assessment, visually inspecting lines and drains, sweeping the room for safety hazards, and analyzing the cardiac rhythm on the heart monitor. Conducting a focused assessment may include checking the level of consciousness, orientation, and sensation, as well as checking for high-risk medications, which were observed 15 times pre- and 29 times post observations. The staff nurses were also encouraged to visually inspect any wound or skin issues, examine intravenous catheters (IVs) and trace the tubing, check any indwelling catheters, tubes, and drains, which were observed 15 times pre- and 29 times post. These items were not separated on the checklist, and nurses were given credit for completing at least one item. The AHRQ also recommends that nurses visually inspect the room for safety concerns, which may include ensuring fall risk precautions are in place, such as bed alarms, and verifying that there is appropriate equipment, supplies, and isolation precautions available. This was observed in 13 of the pre-observations and 27 post-observations. Checking the telemetry rhythm is important as rhythms can change quickly. Bedside nurses were observed checking 18 pre- and 29 post-patients.

Several items are important for patient satisfaction. Staff nurses infrequently completed the AHRQ-suggested patient satisfaction items, such as updating the whiteboard, asking patients and their families about their concerns and goals, and following up to ensure these concerns and goals were met. Patients/families were asked if their previous goals were met or what could have gone better zero times during the pre-observations, with 15 patients unable to participate. During the post observations, patients were asked once, with nine patients unable to participate. Patients

were asked if they had any worries or safety concerns they would like to share, zero times prior to and three times post, with 15 and nine patients unable to participate. Another specific question raised by the AHRQ is to ask patients and families about their goals for the next shift. This was completed zero times in the pre-observations with 15 patients unable to participate, and four times in the post-observations with nine patients unable to participate.

The baseline BSR observations revealed that few nurses completed a bedside report, and when they did, it was often not completed as designed. For example, nurses would enter the room and begin giving reports in the corner or quietly, without explaining to the patient or family or inviting them to participate. One patient, whom the nurses described as being confused, asked why the nurses were talking about him halfway through the report, as they had not introduced themselves to the patient or explained why they were in the room. With the introduction of the modified BSR, there appeared to be some improvement, as evidenced by the consistent completion of items. With more time, the numbers would have continued to improve. As seen in Figure 4, the updating of the whiteboards in the patient's room showed an upward increase from weeks two through four of observations.

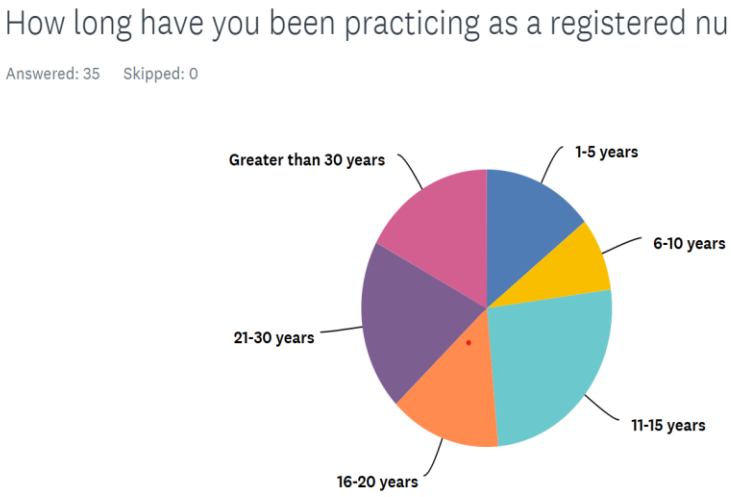
Figure 4: *Observations of Whiteboards being updated at transition of care, Weeks 1- 4*



Nurse Pre/Post Questionnaire

In addition to the observations that provide insight into the project, staff nurses completed an identical thirty-eight-question pre- and post-survey. The survey consisted of one demographic question related to the participants' years of experience as registered nurses. The survey also included 35 multiple-choice questions and two optional open-ended questions. The same group of nurses completed the survey, and a staff roster was used to track who had completed it. Thirty-five nurses completed the pre-survey, and 31 completed the post-survey. Four participants were lost to attrition, including those who left the unit, were on vacation, or were absent due to illness. Figure 5 displays the length of practice as a registered nurse, with 11-15 years being the most common (25.7%), followed by 21-30 years (20%).

Figure 5: *Years of experience as a Registered Nurse*



The survey served as a source for understanding nurses' thoughts toward modified BSR. The survey scores were calculated as a percentage of positive responses on a five-point Likert scale, such as "strongly agree," "agree," and "always" or "usually." A mean was calculated based on a scoring system of one strongly disagree to five strongly agree. An independent t-test was

conducted, and a p-value was calculated to test for significance, with $p < .05$. Table 1 shows the results of the questions, which were evaluated using the independent t-test. Table 2 shows the categorical survey questions that were statistically analyzed using the chi-square test with a significant p-value $p < .05$.

Table 1: ***Pre/Post Survey Percentage Change and Independent Samples t-test Results***

Question	Pre Mean (SD)	Post Mean (SD)	*t*(64)	*p*	Pre %	Post %
Importance of SBAR Process (1= Strongly disagree to 5= Strongly agree)						
It is important for nursing units to have a standardized shift report/handoff process for the transition of care at shift change.	4.49 (0.85)	4.61 (0.50)	-0.71	.482	91.4	100
Frequency of SBAR Process (1= Never to 5= Always)						
Is the unit's standardized process for shift report/handoff for transition of care at shift change consistently completed? (Every day, every shift, every patient).	3.63 (0.94)	4.13 (0.81)	-2.32	.023	51.4	80.6
During shift change, when completing the shift-to-shift report/handoff, I invite the patient and/or family to take part?	3.40 (1.09)	3.81 (1.01)	-1.59	.118	48.6	58
SBAR Information for Patient Information (1= Strongly disagree to 5= Strongly agree)						
Having a poster on the wall in the patient's room that explains the shift report/handoff process helps patients and/or families understand the report process and how they can participate.	3.94 (0.87)	4.03 (1.02)	-0.38	.703	65.7	74.2
Having a patient brochure/pamphlet that explains the shift report/handoff process helps patients and/or families understand the report process and how they can participate.	3.97 (1.01)	4.00 (.73)	-0.14	.890	77.2	80.6
Frequency of SBAR Adherence (1= Never to 5= Always)						
During shift change, when completing the shift-to-shift report/handoff, I introduce the oncoming nurse to the patient and family.	4.49 (0.78)	4.68 (0.60)	-1.12	.269	82.9	93.5
I follow the SBAR (Situation, Background, Assessment, Recommendation) format during shift change when completing the shift-to-shift report/handoff?	4.23 (1.06)	4.58 (0.81)	-1.52	.134	80	93.6
During shift change when completing the shift-to-shift report/handoff, I review tasks such as medication administration (what was given/needs to be given).	4.43 (0.88)	4.61 (0.62)	-0.97	.337	85.7	93.6
During shift change when completing the shift-to-shift report/handoff, I review tasks such as labs and tests that were done or need to be done.	4.69 (0.53)	4.69 (0.68)	0.00	.999	97.1	93.5
During shift change when completing the shift-to-shift report/handoff, I review tasks that were done or need to be done, including required assessments (i.e.,	4.37 (0.77)	4.65 (0.71)	-1.54	.129	82.9	90.3

restraints, admissions, pre-surgery checklists, Theraworx/CHG bath, prior to admission medications, belongings, etc.)						
I use the Professional Exchange Report in the electronic medical record when completing a SBAR (Situation-Background-Assessment-Recommendation) report/handoff for the transition of care between shifts.	2.71 (1.27)	3.42 (1.21)	-2.32	.023	25.7	51.6
I document in the patient's electronic medical record that an SBAR handoff/report was completed (received from/given to) to transfer care at shift change.	3.51 (1.34)	4.06 (1.00)	-1.90	.062	54.3	74.2
I visually inspect wounds, incisions, drains, IV sites, IV tubing, catheters, I-TRACE, oxygen, vents, tracheostomy, etc. during the shift-to-shift report/handoff between nurses.	4.40 (0.69)	4.65 (0.55)	-1.64	.107	88.6	96.7
I conduct a focused assessment of the patient during shift change when completing the shift-to-shift report/handoff?	4.17 (1.04)	4.61 (0.67)	-2.07	.043	80	90.3
If a patient is on telemetry, I check the telemetry rhythm during shift change when completing the shift-to-shift report/handoff?	4.43 (1.04)	4.74 (0.51)	-1.56	.124	85.7	96.8
I conduct a safety assessment of the patient's room (visually sweep the room for any physical safety concerns, equipment, supplies) during shift change when completing the shift-to-shift report/handoff?	4.54 (0.78)	4.68 (0.65)	-0.79	.430	88.6	90.3
During shift change, when completing the shift-to-shift report, I update the patient's whiteboard with relevant information (update communication board in patients' rooms with key staff members names, plan of care, questions, etc.).	3.74 (1.22)	4.29 (0.74)	-2.24	.029	65.7	90.3
During shift change, when completing the shift-to-shift report/handoff, I identify the patient's and/or family's concerns by asking, "Do you have any worries or safety concerns you would like to share?"	3.91 (1.04)	4.35 (0.79)	-1.95	.056	62.9	87.1
During shift change, when completing the shift-to-shift report/handoff, I identify the patient's and family's needs or concerns by asking, "Were your previous shift goal(s) met? What could have gone better during the last 12 hours?"	3.09 (1.40)	3.61 (1.11)	-1.68	.098	42.9	54.8
During shift change, when completing the shift-to-shift report/handoff, I ask the patient and/or family, "What are your goals for this shift/the next 12 hours?"	3.26 (1.40)	3.61 (1.20)	-1.09	.278	48.6	54.8
Familiarity Items (1= Not at all familiar to 5= Extremely familiar)						
Are you familiar with the modified/partial/blended bedside report?	2.71 (1.23)	3.87 (0.81)	-4.57	<.001	25.7	67.7
Are you familiar with the Agency for Healthcare Research and Quality's (AHRQ) Bedside Shift Report Checklist?	2.46 (1.20)	3.03 (1.14)	-1.98	.052	22.9	32.3
Perceptions of Benefits of SBAR (1= None at all to 5= A Great Deal)						
Do you feel that conducting the full bedside shift report (Entire shift report is given Infront of patient/family) at the bedside increases patient and/or family satisfaction?	3.63 (1.24)	2.94 (1.53)	2.00	.051	51.4	38.7

Do you feel that conducting a modified/partial/blended bedside report where part of the handoff (SBAR Report) is done away from the patient at the nurses' station and part of the handoff (Safety Check and introduction) is done at the bedside improves patient and/or family satisfaction?	3.74 (1.24)	4.19 (0.87)	-1.72	.090	60	83.9
Do you believe that conducting full bedside shift reports (entire report is given in front of patient/family) at the bedside improves patient safety?	3.66 (1.30)	3.13 (1.46)	1.55	.127	57.2	38.7
Do you believe that conducting a modified/partial/blended bedside report where part of the handoff (SBAR report) is done away from the patient at the nurses' station and part of the handoff (Safety check and introduction) is done at the bedside improves patient safety?	3.66 (1.11)	4.16 (0.97)	-1.95	.055	62.9	80.6
Do you believe that conducting a modified/partial/blended bedside report where part of the handoff (SBAR report) is done away from the patient at the nurses' station and part of the handoff (Safety check and introduction) is done at the bedside improves nurse satisfaction?	3.66 (1.26)	4.23 (0.81)	-2.21	.031	60	90.3
Do you believe that conducting full bedside shift reports (Entire report is given in front of patient/family) improves nurse satisfaction?	3.23 (1.29)	2.81 (1.54)	1.19	.238	45.7	41.9
Evaluation of Modified Report (1= Strongly disagree to 5= Strongly agree)						
I believe that the modified/partial/blended bedside shift report where part of the report is giving at the nurses' station (SBAR report) and part of the report is given in the patient's room (Safety check and introduction) feels like a more natural way to give report than a full bedside report where the entire report is given at the bedside in front of patient/family.	3.97 (0.95)	4.55 (0.89)	-2.56	.013	71.4	90.3
I have adequate training and/or resources to complete a modified/blended/partial bedside shift handoff?	3.85 (0.89)	4.55 (0.62)	-3.74	<.001	71.4	93.6

Note. Items highlighted in gray were statistically significant.

Table 2: *Chi-square test results for Pre and Post Items*

Item	Pre n (%)	Post n (%)	X^2	P
Does this nursing unit have a standardized process for completing the nursing shift report/handoff for the transition of care at shift change?				
No	3 (8.6%)	1 (3.2%)	1.78	.411
Unsure	1 (2.9%)	0 (0.0%)		
Yes	31 (88.6%)	30 (96.8%)		
Do you think patients and/or their families are aware that nurses are supposed to complete the shift-to-shift report/handoff at the bedside?				
No	12 (34.3%)	7 (29.0%)	.968	.616

Not Sure	9 (25.7%)	10 (32.3%)		
Yes	14 (40.0%)	12 (38.7%)		
On average, how long does it take to complete the SBAR (Situation-Background-Assessment-Recommendation) report/handoff process where the oncoming nurse is updated about the patient's condition for one patient				
1-2 minutes	1 (2.9%)	0 (0.0%)	1.36	.995
2-3 minutes	2 (5.7%)	1 (3.2%)		
4-5 minutes	3 (8.6%)	2 (6.5%)		
5-6 minutes	2 (5.7%)	2 (6.5%)		
6-7 minutes	4 (11.4%)	3 (9.7%)		
7-8 minutes	3 (8.6%)	3 (9.7%)		
8-9 minutes	1 (2.9%)	1 (3.2%)		
9-10 minutes	9 (25.7%)	8 (25.8%)		
Greater than 10 minutes	10 (28.6%)	10 (32.3%)		
What report/handoff process should be the unit's standard for shift-to-shift report/handoff?				
Full bedside report (the entire shift report/handoff is done at the bedside in front of the patient and/or family). No part of the report is done at the nurses' station/outside of patient's room.	13 (37.1%)	2 (6.5%)	9.58	.008
Modified/partial/blended bedside report where part of the handoff (SBAR Report) is done away from the patient and part is done at the bedside (Safety check and introduction). It is acceptable to complete part of the report at the nurses' station.	22 (62.9%)	28 (90.3%)		
Other	0 (0.0%)	1 (3.2%)		
What is the best name for conducting a bedside report where part of the handoff (SBAR Report) is done away from the patient at nurses' station and part of the handoff (Safety check and introduction) is done in the patient's room at the bedside? What do you think this type of report should be called?				
Blended Bedside Report	10 (28.6%)	9 (29.0%)	.431	.980
Hybrid Bedside Report	8 (22.9%)	6 (19.4%)		
Modified Bedside Report	14 (40.0%)	14 (45.2%)		
Other (please specify)	1 (2.9%)	1 (3.2%)		
Partial Bedside Report	2 (5.7%)	1 (3.2%)		

Note. Items highlighted in gray were statistically significant.

In the baseline survey, 85% of nurses reported that the unit had a standardized approach to nurse handoff; however, only 51% reported that it was consistently followed. Ninety-one percent of nurses in the pre-survey believed it was important for a nursing unit to have a standardized process for shift handoffs, which increased to 100% after the survey. Less than 50% of the nurses in the presurvey reported inviting patients/families to participate in shift-to-shift reports (48.6%), using the professional exchange report (25.7%), identifying if a patient's previous shift goals were met (42.9%), or asking about the patient's goals for the next shift (48.6%). Approximately 86% of the nurses reported checking the telemetry rhythm in the presurvey, which increased to 96.8% in the post-survey. Conducting a focused assessment at shift change also increased from 88.6% to 90.3%. The outgoing and oncoming staff nurses reported reviewing tasks together, such as lab tests (97.1%) and medication administration records (85.7%). Most staff nurses in the unit were unaware of the modified bedside process (25.7%) and were unfamiliar with the AHRQ Bedside Shift Report (22.9%) at baseline.

The study's baseline data were compared to post-survey data, which showed an increase in several key indicators. Nurses reported an increased awareness that the unit had a standardized handoff process (96.2%) and agreed that the standardized process was followed 80.6% of the time, compared to 51.4% in the pre-survey. Safety items such as completing a focused assessment, visually sweeping the room for safety concerns, and visually inspecting all wounds, drains, IV tubing, and catheters increased to 90.3%, 90.3%, and 96.7%, respectively.

Patient satisfaction behaviors, such as inviting the patient or family to participate in handoffs, introducing the oncoming nurse, and updating the whiteboard, improved to 58%, 93.5%, and 90.3%, respectively. A slight increase was reported in identifying patient/family

concerns, asking about the patient's shift goals, and inquiring whether their previous goals were met, at 54.8%, 54.8%, and 87.1%, respectively.

Reviewing tasks, such as labs and tests, saw a decrease from the pre-test (97.1%) to the post-test (93.5%). Another pre/post question that saw a decrease was if patients/families are aware that nurses are supposed to complete the shift-to-shift report/handoff at the bedside, with yes (40% pre and 38% post), no (34.3% pre and 26.9% post) and unsure (25.7% to 34.6% post).

The patient education materials, including the brochure and poster, showed a slight increase from the brochure (77.2% pre to 80.6% post) and the poster (pre 65.7% to 74.2% post). The nurses' perception of how long the report takes on average increased from the pre-survey. Most nurses in the pre-survey reported that handoff of one patient took 9-10 minutes (25.7%) and more than 10 minutes (28.6%). Nurses in the post-survey reported that the handoff of one patient took 9-10 minutes (26.9%) and more than 10 minutes (34.6%).

Another key portion of the survey inquired about nurses' perceptions of the modified BSR compared to the full BSR, specifically related to patient safety and satisfaction, nurse satisfaction, and whether nurses felt that the modified BSR was a more natural approach to giving reports. Nurses' perception of modified BSR on patient safety increased from 62.9% to 80.6%. The bedside nurses' perception of whether modified BSR improves patient/family satisfaction went from 60% in the pre-survey to 83.9% in the post-survey. The modified BSR's impact on nurse satisfaction went from 60% to 90.3%. Finally, the pre- and post-survey results related to whether nurses perceived the modified BSR as a more natural way to transition care between shifts increased from 71.4% to 90.3%.

The nurse's perception of full BSR, which was the unit's transition of care method prior to this QI project, decreased in favorability among nurses. In the pre-survey, nurses were asked if

the full bedside report increased patient/family satisfaction, 51.4%, decreased to 38.7% post. Regarding patient safety, 57.2% of staff nurses indicated in the pre-survey that full BSR improves patient safety, which decreased to 38.7% post-survey. The nurses' perception of full BSR on nurse satisfaction decreased from 45.7% pre to 41.9% post.

The number of nurses who thought the modified bedside report should be the unit's standardized approach increased from 62% to 88.5%. In comparison, the full bedside report decreased from 37.1% to 7.7%. Additionally, 50% of the nurses in the post-survey thought that the blended style of bedside report should be referred to as a modified bedside report, which would help standardize the process.

Independent sample t-tests were conducted for each item to compare mean scores on a one-to-five scale at pre- and post-implementation. The results are displayed in Tables 2 and 3. Nine results demonstrated statistically significant improvements from the pre-surveys to the post-surveys. Respondents reported a significant increase in the consistent completion of the unit's standardized process for shift report/handoff at every shift and for every patient. The mean score increased from 3.63 (SD =0.94) at pre-survey to 4.13 (SD =0.81) at post survey, $t(64) = -2.32$, $p = .023$. The second significant improvement was the frequency at which nurses conducted a focused patient assessment during shift change, with a pre-survey mean of 4.17 (SD = 1.04) increasing to 4.61 (SD = 0.67) at the post-survey, $t(64) = -2.07$, $p = .043$. Using the professional exchange report in the EMR indicated a pre-survey mean score of 2.71 (SD =1.27) and a post-survey mean score of 3.42(SD =1.21), $t(64) = -2.32$, $p = 0.023$. Updating the whiteboards showed a significant increase, with a pre-survey mean score of 3.74 (SD =1.22) and a post-survey result of 4.29 (SD =0.74), $t(64) = -2.24$, $p = .029$. Nurses also statistically demonstrated their familiarity with the concept of a modified BSR. The pre scores

2.71 (SD =1.23) increased to 3.87 (SD =0.81), $t(64) = -4.57$, $p = <.001$. Nurses reported adequate training with the modified BSR process; pre-scores increased from 3.85 (SD =0.89) to 4.55 (SD =0.62), $t(64) = -3.74$, $p = <.001$. Another significant result was whether nurses thought the modified BSR was a more natural way to conduct the transition of care handoff. The pre-survey results were 3.97(SD =0.95) and post-survey results 4.55(SD =0.89), $t(64) = -2.56$, $p = 0.013$. The last statistically significant result was from a question with a categorical response regarding which method should be the unit's handoff process. The full bedside report decreased from pre-survey 37% to 7.7% post-survey. The modified BSR increased from 62.9% pre-survey to 88.5% post with x^2 (2, N=66) =9.58, $p = .008$.

Qualitative Analysis

The open-ended questions, one-on-one interviews, and shared leadership focus groups have yielded valuable insights into the challenges encountered by nursing staff. Staff nurses identified language barriers, time constraints, and distractions as the primary obstacles faced during bedside handoffs. These findings highlight the complexities of the nursing profession and the dedication of its practitioners to addressing these challenges. Open-ended survey responses were analyzed using a thematic analysis approach to identify patterns related to perceived barriers and recommendations for improving bedside shift handoffs. Themes were developed based on recurring concepts. Quotes were selected to represent each theme, providing insights into participants' perspectives on the shift handoff process.

Participants provided open-ended responses regarding their experiences and suggestions for bedside shift handoff. Thematic analysis revealed several barriers that hinder the effective implementation of partial or full bedside handoffs, as well as a range of recommendations aimed at improving the process. These findings provide additional insight into staff nurses' perceptions

of modified BSR, as the most frequently cited barriers included interruptions, time constraints, family presence, and inconsistent nurse engagement, as shown in Table 3.

Table 3: *Barriers based on nurse comments*

Theme	Definition	Example Quotes
Interruptions and Distractions	Frequent disruptions from patients, families, or coworkers during report.	"Multiple interruptions can affect the flow of which side report can affect the care that needs to be given."
		"Interruptions from family and patient… tend to prolong handoff."
Time Constraints	Perception that bedside handoff takes too long and delays shift change.	"Takes too long."
		"Having to clock out by a certain time."
Family Presence and Privacy	Difficulty being candid in front of patients/families due to confidentiality.	"The nurse cannot be completely honest of the patient history or safety risk."
		"Sensitive information… may not be said in front of the patient."
Non-Compliance and Variation	Inconsistencies in nurse participation or handoff style.	"Some nurses are not compliant in doing everything."
		"Coworkers have their preferences."
Patient Acuity and Mental Status	High-acuity or difficult patients make bedside handoffs impractical.	"Patient mental status and acuity."
		"Patient that are difficult."
Environmental and Structural Barriers	System, space, or documentation limitations that hinder handoff.	"Frequent changes or modifications… leave room for mistakes."
		"Reducing the number of clicks…"

The staff nurses also provided recommendations that focused on standardizing the process, offering incentives, enhancing training, and increasing managerial involvement. These insights offer actionable opportunities to enhance the consistency and quality of bedside handoff protocols, particularly as the modified BSR is implemented in additional inpatient nursing units. Table 4 lists some recommendations from staff nurses regarding ideas for improving the shift-to-shift transition of care handoff process.

Table 4: *Recommendations based on Open-Ended Responses*

Theme	Definition	Example Quotes
Standardized and Structured Process	Support for a consistent, checklist-based, or scripted format.	"Use Big Picture/History, System assessment, Aims in place of SBAR."
		"Given systematically including the last 24hrs…"
Incentives and Recognition	Encouraging nurse participation through praise or rewards.	"Give incentives to nurses… a shout out in an email, extra kudos during annual review."
Training and Reinforcement	Calls for more education and reinforcement of proper protocols.	"Good improvements. Will be implementing… don't standardly use SBAR."
Managerial Support	The value of having nurse leaders observe and support handoffs.	"It seems reports go well when managers observe nurses."
		"Managers be there."
Safety Integration	Using bedside handoff to complete safety checks and room scans.	"Visual checking of the room to improve patient and staff safety."
Flexibility and Autonomy	Empowering nurses to use judgment in adapting the handoff process.	"Acknowledging nurse autonomy to make the best choices for their patients."

The results indicate several positive shifts following the implementation of a modified BSR. Quantitative findings revealed statistically significant improvements in nurse familiarity with the modified BSR, confidence in completing the handoff, consistency in using the process, and conducting focused patient assessments during handoffs. Nurses also indicated in the survey that they used the professional exchange report more frequently and updated the whiteboards in patient rooms, with statistically significant improvements noted in the post-survey. The survey results also showed a significant increase from pre- to post-test in terms of staff nurses preferring the modified BSR process as their standardized approach to the shift-to-shift transition of care, indicating that it feels like a more natural way to give reports, which improves nurse satisfaction with the handoff process. Qualitative analysis revealed insights into the barriers nurses face

during bedside handoffs, including interruptions, language barriers, time constraints, and challenges related to privacy and consistency in completing the report. Participants recommended standardizing the process, providing incentives and recognition for those who consistently complete BSR, and involving management, which may support the effectiveness and sustainability of bedside handoff practices. The evaluation of the results and conclusions will be discussed in the next section.

CHAPTER SIX: DISCUSSION

The Doctor of Nursing Practice (DNP) Scholarly project aimed to evaluate nurses' perceptions of a modified bedside report (BSR) in terms of patient safety and satisfaction, nurse satisfaction, and whether the process appears more natural and sustainable compared to a full bedside report. The project was completed in a 22-bed intensive care unit as a pilot unit to examine the process and develop a nurse-driven handoff protocol that utilizes Kotter's change management theory to create a process that could be expanded to additional inpatient units.

The selected organization, like many other acute care hospitals worldwide, has struggled with sustaining BSR as its standardized handoff process. Several interventions were implemented, and feedback was obtained from a nursing survey, focus groups with the unit's Shared Leadership Committee, and one-to-one interviews with staff nurses. In addition, observations of the handoff process were conducted to gain a deeper understanding of the process and promote staff nurse involvement in evaluating the effectiveness of a modified BSR on their practice.

The AHRQ created a BSR Checklist in 2013 that identifies the key items to be discussed during bedside handoffs. The checklist was modified to include additional items that the organization has listed in its handoff policy, and items were identified that could be completed at the bedside or outside of the room. Grimshaw et al. (2020) recommend that nurse leaders allow staff nurses to divide BSR into two sections, where the main report and sensitive information are discussed outside of the patient's room, and introductions and safety checks are done at the bedside. The modified AHRQ checklist was used during the project to conduct 30 pre- and post-

implementation observations, as well as ten weekly observations over four weeks, during which feedback on the process was provided to staff nurses when checklist items were not completed.

The results supported the project's aim that a modified BSR could serve as a viable alternative to a full BSR. After providing brief training to nurses using a PowerPoint presentation emailed to staff nurses, followed by huddles and discussions at meetings about the modified BSR, and creating a brochure and poster for patient education about the process, there was an improvement in several key areas. Nurses overwhelmingly completed more items on the AHRQ Checklist, including key safety items such as conducting a focused assessment, visually inspecting wounds, incisions, and drains, and visually sweeping the patient's rooms for safety concerns. These actions may reduce potential harm and reduce patients' perceptions of enhanced safety while hospitalized. The observations also revealed that inviting patients and families to participate in the handoff process and introducing the incoming nurse increased. These actions may encourage patients to feel more comfortable speaking up and contributing to the report. It may also potentially reduce patient anxiety related to shift changes, which can lead to increased patient satisfaction with the quality and level of service provided at the hospital, as noted by Bressan et al. (2019).

The literature review highlighted a need for a standardized approach to handoff, which the staff nurses in this project agreed was important. The organization utilizes an SBAR (Situation-Background-Assessment-Recommendation) report process, which was consistently completed in most post-observations and reported by the nurses who took the survey. This aligns with Desmedt et al. (2020), who conducted a meta-synthesis, acknowledging that multiple approaches to handoff communication, including checklists and mnemonics, did not matter as much as having a standardized process in place and providing high-quality handoffs. Similar to

the results of this project, Brown-Deveaux et al. (2022) found that implementing a change management strategy and a standardized approach to BSR led to increased nurse compliance with the process and higher patient satisfaction scores. According to the survey results of this project, nurses understand the importance of completing a high-quality standardized handoff; however, they did not select full BSR as the best option to accomplish this goal. The results highlight the need for inpatient units to have a standardized process that works effectively within their units. The modified strategy appears to be a better approach than full BSR. However, it still requires additional iterations to fully understand why some of the AHRQ checklist items were not completed as frequently.

Several patient-centered questions aimed at promoting patient involvement and satisfaction showed minimal improvement following the implementation of a modified BSR and nurse education on the AHRQ modified checklist. For example, asking the patient or family whether their previous goals had been met was only asked once during the post-observation period. Asking patients if they have any safety concerns or worries was asked three times. Asking the patient or family about their goals for the upcoming shift was asked four times. Many nurses reported that they typically discuss the plan of care and goals with patients later in the shift, which may account for the survey data showing that 48.6% of nurses said they asked, but this was only observed four times in the post-observations. There may be several benefits to this aspect of care planning during shift change, including having a standardized approach that facilitates patient participation. It also may promote participation because the patient may still have rapport with the outgoing nurse and feel more comfortable answering questions.

Asking patients questions about whether the organization is meeting their goals and discussing safety concerns provides an understanding of how patients perceive their care,

encourages patients to become active participants, and ensures nurses are aware of the patient's main goals for the shift, whether it was pain management, speaking to a doctor, or consulting with a social worker. One example that stood out during the observations was when the DNP project leader coached two nurses after an observation to encourage them to ask patients these questions. The nurse stated that the patient was confused. The DNP project leader encouraged the incoming nurse to ask the patient what their goal was for the day, and the patient said, "to eat breakfast." This served as a reminder to nurses that even confused patients have needs and nurses can encourage their participation in care planning. Asking the question takes only a few seconds, but it can have a profoundly meaningful impact on the patient. Other needs that are important to patients and may be overlooked include washing their hair, calling a loved one, or taking a walk in the hallway. Consistently asking these questions during handoff may provide a template for identifying patient needs and providing patient-centric care. Further iterations and conversations with individual nurses, as well as with the Shared Leadership Committee, are needed to gain a deeper understanding of the barriers to achieving higher compliance in this area and to gather suggestions for improvement.

In terms of nurse satisfaction, many nurses expressed increased approval of the modified BSR, while their view towards the full BSR decreased. Nurses also reported that the modified BSR seemed like a more natural way to complete the report. Comments from nurses included, "this is how we used to give report," and "it makes more sense to talk outside the room and then go check on the patient." One nurse also expressed content with being included in the process of evaluating the modified BSR process, stating, "Normally, administration just tells us what to do. I have never been asked my opinion before." During the project, nurses expressed concerns about patient privacy, distractions, interruptions, and the increased time required to complete the

full BSR. Taking these concerns into account will impact nursing satisfaction with the process and, hopefully, lead to continued performance with the modified BSR. Furthermore, highlighting the benefits of modified BSR on the nurses' practice in terms of preventing harm, improving communication, and reviewing tasks at shift change may lead to nurses' buy-in with the process and consideration of the benefits.

Scrhim et al. (2018) found that nurses acknowledged several positive benefits of BSR, including promoting professionalism, enhancing patient safety, increasing communication, and fostering therapeutic relationships with patients and their families. However, they acknowledged the disadvantages, such as increased report time, interruptions, repetition of information, privacy issues, and that these concerns should be taken into consideration to improve nurse satisfaction with the process. The modified BSR is a standardized option that takes these into account and promotes a consistent approach to handoff. Nurses in the study overwhelmingly believed that a standardized approach to handoff was important.

Standardizing the approach to shift-to-shift transition of care through the modified BSR is not a perfect system and has its downsides. Some patients enjoy being part of the full BSR and appreciate ensuring that the information reported is timely and accurate. Some patients enjoy the interaction that BSR offers and want to hear about any abnormal assessment or test results. Some patients appreciate being able to ask questions and have nurses explain aspects of care to them and their family during the report. The modified BSR may overlook some of these concerns to a certain degree. However, if nurses consistently complete the questions aimed at including patients in the handoff process and evaluating their perception of care, patients may benefit from being informed about their care while addressing some of the other concerns about full BSR. As one qualitative comment pointed out, "a certain degree of flexibility and autonomy" may be

needed to empower nurses to “use their judgment in adapting the handoff process.” This may lead to stronger results in the QI project, particularly in terms of its outcome measures, system changes, and balancing measures.

Quality improvement projects can be evaluated in terms of the outcome measures, system changes, and balancing measures. Nurses reported that the modified bedside report improved patient satisfaction with handoff communication, increased perceptions of safety, and enhanced compliance with the standardized handoff protocol, which were key outcome measures. Process measures included consistent use of the SBAR format during shift reports, increased staff participation during handoffs, and development of a formal organizational policy supporting modified BSR. The balancing measures were focused on balancing staff satisfaction with patient needs. Some patients may benefit from a full BSR and may want to be more involved in their care, while others may not benefit from BSR. Nurses may need to exert autonomy in their practice when assessing patients’ needs, while also considering the unit’s standardized process for completing handoffs.

The DNP Scholarly Project should also be evaluated in terms of its fiscal impact on meeting the project’s outcomes. The project's economic value was positive. The project incurred minimal direct financial costs, with most expenses being attributed to the time required for completing observations and training. There were also costs associated with printing the brochures and creating posters for the wall. The project has the potential to reduce both communication-related and quality-related errors, which can be costly financially, as well as have emotional and life-changing effects on patients. Although HCAHPS scores were not part of the project, improved patient scores can lead to increased hospital reimbursement, value-based purchasing, and hospital reputation. Future studies could look specifically at the impact of

modified BSR on improving HCAHPS scores. O'Donnell (2023) conducted a multi-hospital study that found BSR led to increased HCAHPS scores—a similar study could be conducted to examine the effects of modified BSR on HCAHPS scores.

The impact of the DNP Scholarly Project on the American Association of Colleges of Nursing (AACN) DNP Essentials for domains five, seven, eight, and ten revealed improvements throughout the project. Domain five focuses on providing safe care that enhances quality, system effectiveness, and person-centered care, reduces errors, and encourages safer work environments (AACN, 2021). The results from the survey demonstrated that nurses' perception of modified BSR would lead to safer care and impact patient satisfaction scores. The observations of handoff also showed that many of the handoff behaviors identified by the AHRQ in the BSR checklist were completed more frequently after the implementation of the modified BSR. Domaine Seven focuses on improving systems-based practice in healthcare organizations. DNP-trained nurses are positioned to implement QI projects aimed at making improvements that meet the objectives of the Institute for Healthcare Improvement (IHI).

In terms of meeting the goals of the IHI's quintuple aim, the project achieved improvements in quality and satisfaction, population health, cost reduction, clinical well-being, and health equity. Nurses anticipated that the process would improve patient and nurse satisfaction with the handoff process. Population health improvements were achieved through enhanced patient involvement in their care. This is important for patients in a safety net hospital system like the County, where patients may have more social determinants of health that impact their overall health and health equity. Fewer communication breakdowns and improved efficiency may lead to lower costs. Clinician well-being creates a sense of teamwork and reduces stress during handoffs. Encouraging individual patient engagement during shift reports can lead

to better health equity. Although the results of this study in achieving the goals of the IHI's quintuple aim are promising, future studies could be conducted to measure these areas and identify further areas for improvement.

The AACN's Domain Eight focused on informatics and healthcare technologies. The results showed an increase in the use of the professional exchange report in the EMR during the report. Staff nurses made specific suggestions related to the professional exchange report that led to the ICU unit manager putting in requests with the Information Technology (IT) department to streamline the professional exchange report and make it more user-friendly, including adding an area to document a two RN skin assessment and document who the report was given to. Feedback from staff nurses related to the professional exchange report was that it was "too busy" and "required scrolling down to get the most helpful information." Additional iterative cycles could be completed to gather further information on how to make the professional exchange report more user-friendly, thereby facilitating the standardization of the report process. During observations, if staff nurses do not use the professional exchange report, they frequently jump from page to page in the EMR, such as results, physician progress notes, physician history and physical notes, medication administration pages, and the section in the EMR that shows wounds and any lines or drains. The professional exchange report consolidates all this information on one page, which helps nurses quickly access the necessary details, reduces the report's length, and adheres to the standardized handoff process. Staff nurses did not fully embrace the professional exchange report, which creates an opportunity for further improvement.

The project's theoretical framework provided a basis for implementing and evaluating changes within the healthcare system. Kotter's eight steps to change served as the foundation for effectively promoting change during this project. A sense of urgency was created by having

nurses identify the potential harm that could occur when handoffs are not completed with patients at the bedside. A guiding coalition was formed, comprising the unit's leadership team, the Shared Leadership Committee, and individual staff nurses who provided valuable feedback aimed at improving the shift-to-shift transition of care process. The vision was established to develop a nurse-driven protocol that would replace the full BSR, which was not consistently being followed. Replacing the full BSR with a process that still achieved many of the reported benefits of BSR, while taking into consideration the barriers to BSR implementation, was crucial to the process. Nurses received training to participate in the project, and barriers were identified and addressed during the project. Short-term wins were identified by thanking staff nurses for their participation and feedback, as well as during key milestones. A pizza party was held at the one-month project milestone. The next steps in sustaining the change and permeating the organizational culture will be crucial for ensuring the project's continued success. Although various change management frameworks could have been used, Kotter's framework provided a structured approach that allowed for iterations and constant improvement aimed at promoting sustainability.

The project's results inform the clinical phenomenon by offering an alternative to a system that does not work in all organizations. Despite the time and effort placed in training and trying to enforce BSR, there may be inherent challenges that prevent nurses from fully embracing this practice. It may appear that nurses are resisting BSR, but many nurses view the BSR as a process that is inefficient and impractical at times. Nurses reported that it is not practical when patients are confused or when there are privacy concerns, which may affect the changes in clinical practice.

An executive summary (See Appendix M) and an updated policy (See Appendix N) were developed to guide the expansion of modified BSR to other units and to incorporate it into any future onboarding education. Suppose the project is expanded to additional inpatient units. In that case, it will be important to utilize the ICU Shared Leadership Committee to develop a list of lessons learned that will influence future practice.

One area for improvement in the DNP Scholarly Project is to enhance communication. It would have been beneficial to provide more frequent communication, such as weekly emails with the results. Calculating the results from the observations and posting them may have improved transparency and adherence to the specific items on the modified AHRQ checklist. In addition, using agile project management tools, such as a Kanban Board, may have improved teamwork, transparency, and adherence to project aims by displaying the work that needs to be completed, is in progress, and what has been accomplished. Furthermore, using more traditional waterfall project management tools, such as having an issues log, a Gantt chart, and a robust communication plan, and making them more visible to staff nurses, may have improved the outcomes of the DNP Scholarly Project. It is recommended that a lessons learned document be created from the current ICU Shared Leadership team, which can serve as a starting point for implementation in additional units. Creating a task force with representation from all inpatient units may help further promote the objectives of having a nurse-driven handoff process that improves communication and consistency with the process.

Limitations

The questionnaires and other materials used in the DNP Scholarly Project pose validity concerns as they have not been previously validated. The questionnaires were based on items identified in the literature review, which provided insights into the specific QI project. Many

validated surveys related to this topic are based more on nurses' perceptions and experience with BSH and are not explicitly geared towards modified BSH. In addition, the survey employed a five-point Likert scale, but also utilized various scales of measurement, including disagree-agree, never-always, familiar-not familiar, and none at all-a great deal. These different response scales could have been confusing to participants and affected their responses. Furthermore, some of the questions were asked in the second person, while others were asked in the first person, such as "do you feel" and "I believe." Having a more consistent approach to developing the questionnaire may be beneficial for future studies.

The duration of the study can also be an internal threat. The study was conducted over a two-month period to comply with the DNP timeline. More time may have been needed to see the effects of the intervention and make recommendations. Additional iterations with the Shared Leadership Committee may have provided additional insight, especially in terms of how to ask pertinent patient-centered questions that increase patient involvement, evaluate patients' concerns, and assess patient satisfaction with their care.

Threats to external validity include the fact that the QI project was not a randomized, controlled experiment. Multiple interventions were implemented simultaneously. Confounding factors were not controlled, making it challenging to generalize the findings beyond the study. The sample size was small. The study was conducted in a single hospital unit, located in a specific area of the state and country. Future research could include a multicenter, longitudinal, experimental study designed to evaluate the interventions independently and analyze the results using inferential statistics. Partnering with a Doctor of Philosophy-trained nurse-scientist could promote strategic partnerships that promote such research studies.

Project limitations can also include the fact that some staff nurses may become resistant to implementing novel changes and will find workarounds. Despite developing a system that nurses reported was a more natural way to provide reports, some nurses may still not follow the standardized approach. This was observed in some of the qualitative feedback provided by staff nurses, who listed inconsistencies with completing the modified BSR, noting that nurses should not have to use the professional exchange report, and that coworkers have their preferences on how the report should be conducted. Some of the comments noted that compliance with the modified BSR was more consistent when the management team was observing reports, a finding similar to those reported about the full BSR.

Implications for Clinical Research

The DNP Scholarly Project aimed to improve the BSH process in one healthcare system. The project acknowledged that while BSH is a critical practice for ensuring patient safety, effective communication, and continuity of care, it is often inconsistently applied, resulting in variability in quality and outcomes. The literature review supported the implementation of a standardized BSH as a component of patient safety, communication, and quality of care. Future research could investigate the most effective tools and approaches for standardizing the modified BSH.

The lack of patient education and knowledge about participating in BSH was also a barrier to sustaining BSH. The solution was to provide a visual poster and patient brochure in the admission folder that describes the BSH process. The interventions could be studied independently to identify whether they are effective for patient education about the BSH process. Patients should be surveyed, and their understanding of the BSR process should be observed to gain insight into the phenomenon.

The DNP Scholarly Project addressed the ongoing debate between full and modified BSH approaches and asked nurses' perception of the impact of modified BSR on patient and nurse satisfaction and safety. Full BSH has been the standard in many studies; emerging evidence supports the benefits of a modified or blended approach, particularly in addressing the concerns of both patients and nurses. Jimerson et al. (2020) and Grimshaw et al. (2020) found that a modified BSR, which combines bedside communication with handoffs at the nurses' station, can alleviate some of the time constraints and privacy concerns associated with traditional BSR while still maintaining patient involvement and safety. Future research should be conducted with methodologies that promote a better understanding of the benefits of modified BSH.

The results of the DNP Scholarly Project through the QI process may not be generalized to other organizations. The findings of the DNP Scholarly Project provided the selected organization with valuable insights into interventions that may enhance care and inform the process throughout the organization. As with all QI projects, the process will need to be studied and refined, especially as new knowledge, technology, and processes become available.

The handoff process may also be improved by implementing technologies such as barcode scanning and artificial intelligence (AI). With the emergence of AI, there may be opportunities to continue improving safety and communication during shift-to-shift transitions of care. AI tools may be able to compile handoff reports into user-friendly reports that provide suggestions based on clinical condition tools and the priorities for providing patient care. AI tools, along with integrated tools such as electronic whiteboards, can facilitate the capture of patient questions and concerns, update the plan of care, and identify which staff members are caring for patients. This can be done seamlessly during the shift change process, eliminating the need for nurses to manually update these items.

Technologies, such as barcode scanning, that already exist at the bedside, may be the answer to driving sustainment with modified BSR. Most hospitals utilize barcode scanning for medication administration, improving the quality and safety of patient identification and medication administration. Barakat and Franklin (2020) reported that the rate of patient identification increased from 74% to 100% with the introduction of scanning technology, increasing medication scanning compliance and adding no additional time to the nurse's workflow. Barcode scanning has evolved beyond its initial application in medication administration in hospitals; it is now used to scan blood products, laboratory samples, and even pumped breast milk. Lee et al. (2017) recommended that improving nursing informatics is vital to enhancing the quality, safety, and satisfaction of care. Sparling et al. (2023) found that barcodes are primarily used for medication documentation and are not currently utilized during handoffs. This technology could be used to record the transfer of clinical responsibility. The utilization of barcode scanning technology for BSR, combined with the use of EMRs to generate reports and dashboards (See Appendix O), will enable managers to provide timely feedback to staff nurses. The DNP Scholarly Project aimed to implement the use of barcode scanning technology to track completion of specific items during modified BSR; however, barriers prevented its implementation in the selected healthcare organization.

A phased-in approach may be necessary to explore the integration of barcode scanning technology, aiming to improve compliance with bedside handoffs by building on the success of barcode scanning in reducing medication errors and enhancing the quality of care. This technology could be expanded to enhance compliance and safety during a modified BSH, supporting new and innovative ways of utilizing proven technology to improve compliance with completing a modified BSH. Staff nurses could scan barcodes to record information in the EMR

using a predetermined checklist for handoff essentials. The barcodes would be displayed on a poster in the patient's room, educating patients about the bedside report process and encouraging them to participate (See Appendix P). These initiatives could streamline the process for nurse managers to generate reports from the EMR, assess compliance rates for individual nurses, and facilitate easier auditing. Nurse managers would be empowered to oversee compliance and provide constructive feedback to staff nurses, fostering a culture of safety in care delivery. Utilizing technology would further support the AACN Domain Eight and promote continued safety and high-quality care that does not rely solely on observations or self-reports. Healthcare organizations can strengthen their commitment to the Joint Commission's National Patient Safety Goals and ensure that bedside handoffs are conducted consistently and reliably by leveraging proven technologies.

CONCLUSION

The DNP Scholarly Project implemented a modified BSR based on the AHRQ BSR Checklist in a pilot unit as their shift-to-shift transition of care. The modified BSR was selected as a nurse-driven process to serve as an alternative to the full BSR, which was the unit and organization's process for completing handoff between shift changes. Unfortunately, despite having a BSR handoff process in place, like many other hospitals, the organization struggled to sustain the practice for assorted reasons. The modified BSR, along with a patient brochure and poster for patient education on the process, was implemented to help standardize the handoff process. The Joint Commission and AHRQ recommend that organizations adopt a standardized approach to handoffs that focuses on enhancing effective communication, minimizing errors, and promoting patient involvement, while completing reports in an environment that minimizes distractions and interruptions. The modified BSR is a solution that achieves these aims by designing a handoff process that allows nurses to complete a portion of the report outside of the patient's room, while completing an introduction and safety handoff inside the patient's room. The process was evaluated in terms of nurses' perceptions of its impact on improving patient safety and satisfaction, as well as nurse satisfaction. Additionally, nurses were surveyed to determine whether the modified BSR could serve as the unit's standardized process for completing shift-to-shift handoffs. Implementing a DNP Scholarly Project required change management, project management, and leadership skills that were aligned with the AACN Essentials. The goal was to support a nurse-driven, sustainable, and scalable handoff process that enhances communication, improves safety, and boosts nurse satisfaction, which can be expanded to other inpatient units within the healthcare organization.

APPENDICES

Appendix A: *The Joint Commission 8 Tips for High-quality Hand-offs*



Appendix B: *Fishbone Diagram to Support Problem Statement*



Appendix C: *Using Kotter's Change Management Framework for DNP Scholarly Project*

Kotter's Eight-Step Model for Change	Recommendations from Kotter (2012)	Change Management Actions During Proposed DNP Scholarly Project
Step 1: Establishing a Sense of Urgency	• Shake up the status quo. • Complacency. • Push up the urgency level. • People must be shocked into action. • The role of crisis. • The role of middle and lower managers. • Compelling stories and items that people can see, touch, and feel, and provide visual displays of performance levels.	• Communicate the need for change by sharing data and stories about current issues with shift handovers, such as errors, patient safety incidents, and dissatisfaction. • Encourage nurses to share their personal stories. • Engage stakeholders, including nursing staff, hospital administrators, and patients, and build support and enthusiasm. • Highlight the project's benefits: Emphasize the potential positive outcomes of BSR, such as improved patient safety, better communication, and enhanced patient satisfaction. • Demonstrate how the old system is not working/inconsistent. • Find cases of adverse events such as lawsuits, disciplinary actions, and infections. • Review records for cases/examples. • Encourage bottom-up dialogue that includes those being asked to change.

Step 2: Create the guiding coalition	• Organize a team of influential, effective leaders. • Get the right people, fully committed. • Find the right people. First, identify appropriate staff, solicit their interest, and gain commitment through trust. • Create trust. • Develop a common goal.	• Identify leaders: recruit influential and respected individuals to become department champions for the project. • Identify those who are resistant to engage them. • Form a diverse team with members who have the skills, credibility, and authority to drive the project forward. • Clearly define each team member's role in the project and ensure they are committed to its success. • Minimize status or differences. • Create a code of cooperation and accountability.
Step 3: Develop a vision and strategy	• Developing a compelling vision is essential. • Create an appealing picture of the future. • Communicate how the vision will be achieved. • Create timetables and steps to implement. • Characteristics of a compelling vision: imaginable, desirable, feasible, focused, flexible, communicable.	• Develop a clear vision and strategy to guide the change. • Draft a compelling vision statement that encapsulates the project's goals and benefits. • Outline a plan that includes the steps for training, timelines, and milestones. • Set the stage for involving others. • Communicate the vision through meetings, emails, and posters to ensure everyone understands and is

		aligned with the goals. • Create a vision that appeals to both the head and the heart. • Develop a vision that encourages people to "want to" instead of "have to"
Step 4: Communicate the change vision	• Communicate, communicate, communicate. • Key elements in the effective communication of vision: simplicity, providing a verbal picture (metaphor, analogy, and example), multiple forums, repetition, leadership by example, addressing inconsistencies, and two-way communication.	• Communicate the vision through multiple modes of communication (people hear differently), regular meetings, newsletters, and huddles to communicate the vision and progress continuously. • Address concerns: actively listen to feedback and address staff's concerns or questions. • Highlight early wins. • Share success stories. • Demonstrate the benefits of the new process. • Send clear, credible, and heartfelt messages about the direction of change. • Establish buy-in by having a clear "why" but allowing the group to produce the "How" and provide effective solutions. • Keep communication sincere and straightforward. • Ensure communication is two-way.

		• Find out what people are feeling, such as anxiety, confusion, anger, or distrust. • PDSA feedback, focus groups.
Step 5: Empower employees for broad-based action	• Empower people to act by removing structural barriers. • Removing obstacles will promote confidence in change, allowing people to feel able to act. • Provide needed training. • Align systems to the vision. • Deal with troublesome supervisors/employees.	• Value relationships • Encourage innovative ideas. • Be transparent and inclusive. • Ensure everyone knows what is expected and how to achieve goals. • Remove barriers: Collaborate with the team to identify potential obstacles, such as staff resistance, resource limitations, or technical issues, and address them effectively. • Develop a staff resistance plan. • Provide staff with the necessary resources, training, and support to ensure their success. • Encourage peer-to-peer support and accountability. • Implement strategies to address resistance, such as additional training, one-on-one meetings, or adjustments to the plan based on feedback. • Show how changes are making a difference.

		• Encourage teams to speak up and actively listen. • Understand Roger's law of Diffusion of Innovations (Innovators, early adopters, early majority, late majority, laggards). • Understand change styles (empathizer, includer, analyzer, driver).
Step 6: Generating short-term wins	• Short-term wins provide visible, inspiring examples that change is possible. • The role of short-term wins: provide evidence that sacrifices are worth it, reward change agents with a pat on the back, help fine-tune vision and strategies, undermine cynics and self-serving resisters, keep bosses on board, and build momentum. • Planning for results. • More pressure is not all bad. • Short-term wins are not short-term gimmicks.	• Establish achievable short-term goals and discuss progress made. • Recognize risk-takers and early adopters. • Recognize and celebrate successes. • Build confidence and demonstrate the benefits of change. • Communicate results with all stakeholders that appeal to both hearts and minds. • Emails, huddles, and staff meetings. • Project Status Board. • Thank You Videos
Step 7: Consolidating gains and producing more change	• Resistance: always waiting to reassert itself. • The problem of interdependence. • The nature of change in highly interdependent systems. • Organizational transformations. • Elimination of unnecessary interdependencies.	• Value continuous learning and improvement. • Focuses on systems and processes. • Build on the change by consolidating gains and producing more change. • Review what went well and what can be improved. • PDSA cycles.

		• Integrate feedback into the ongoing process. • Continue to build relationships. • Recognize change agents and informal and formal leaders. • Keep all stakeholders involved. • Encourage executive leadership visibility and support. • Expand implementation gradually to additional units or departments, using lessons learned from initial deployments. • Keep momentum by setting new targets, celebrating continued successes, and reinforcing the vision. • Monitor savings and cost avoidance. • Take time to pause to prevent burnout.
Step 8: Anchoring new approaches in the culture	• Once the change is implemented, it must be ingrained in the organization. • Culture is influential. • New practice can be grafted onto the old culture. • New practices can replace the old culture. • Cultural change comes last, not first: most alterations in norms are shared values that come at the end of the transformation process. • Depending on results: Novel approaches usually become part of the culture only after they work and are superior to old methods. • It requires much talk: Without verbal instruction and support, people are	• Rewards individuals and teams for performance. • Encourage the executive leadership team to acknowledge and praise staff for their improvements. • Report on any gains/improvements to quality organizations, such as Leapfrog. Benchmark against best in class. • Encourage story sharing.

	often reluctant to admit the validity of new practices. • May involve turnover: Sometimes, the only way to change a culture is to replace key individuals. • Deciding on succession is crucial: if promotion processes are not changed to be compatible with the new practice, the old culture will reassert itself.	• Integrate changes into policies to make them a permanent part of the hospital's policies and standard operating procedures. • Ongoing training: Provide continuous education and training for new and existing staff to reinforce the importance and practice of BSR. • Monitor and evaluate effectiveness and make changes. • Make it part of the new RN orientation. • Create a video. • Ensure ongoing competency by making it part of the annual skills day. • Visibly post compliance rates • Ongoing PDSA (annual, after significant errors, drop in compliance). • Monitor literature for updates. • Complete additional QI projects. • Increase accountability by making it part of employee evaluation. • Embed in the culture and align with organizational values/goals/and mission. • Create ongoing huddle messages. • Be able to discuss evidence-based

		practices and best practices with regulatory agencies, such as The Joint Commission. They are usually interested in organizational quality improvement projects or improvements in safety and quality.

Appendix D: *QR Code Feedback Survey Open During the Duration of the Project*

Use QR Code or Link Below to Provide Feedback at Anytime

https://www.surveymonkey.com/r/8CJ389T



Citizen Questions, Comments, & Requests | Norridgewock, ME



Appendix E: *UCLA IRB Exemption Letter*

UCLA Research Administration
Human Research Protection Program

University of California Los Angeles
10889 Wilshire Blvd, Suite 830
Los Angeles, CA 90095-1406
https://ohrpp.research.ucla.edu/

(310) 825-5344
General Campus IRB:
gcirb@research.ucla.edu
Medical IRB:
mirb@research.ucla.edu

UCLA IRB REVIEW NOT REQUIRED

Date:	January 8, 2025
To:	Nathan Barfield SCHOOL OF NURSING
From:	Thomas Coates, PhD Chair, South General Institutional Review Board
RE:	IRB-25-0031 **Study:** Utilizing Barcode Scanning Technology to Measure Compliance with Modified Bedside Report

Funding Source(s): None

Based on the information provided in the BruinIRB application, the UCLA Office of the Human Research Protection Program has determined that the scope of participation does not meet the definition of human subjects research and therefore is not subject to IRB review.

Please note: If, after the project is completed - identifiable data are retained, and the Principal Investigator wishes to analyze those data for purposes beyond the DNP project, at that time a new application should be submitted to the UCLA OHRPP/IRB, to request IRB review and approval of proposed secondary analyses of DNP project data for research purposes.

Appendix F: *AHRQ Nurse Bedside Shift Report Brochure*



You are invited

You are invited to take part in nurse bedside shift report. You can also invite a family member or friend to take part with you.

Nurse bedside shift report happens every day between [7 and 7:30 a.m.] and [7 and 7:30 p.m.].

Let us know if you have any questions. We are partners in your care.

Nurse Bedside Shift Report

What is it?
How can you get involved?

Being a partner in your care helps you get the best care possible in the hospital. Taking part in nurse bedside shift report is one way you can be a partner.

This brochure explains what nurse bedside shift report is and how you can get involved.

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Guide to Patient and Family Engagement

What is nurse bedside shift report?

Nurse shift changes occur when nurses who are going off duty share information about your care with nurses coming on duty. At [insert hospital name], we want you to be involved in shift changes to make sure you get high-quality care.

Nurse bedside shift report is when the nurses going off and coming on duty meet by your bedside to talk about your care. This gives you a chance to meet the nurse taking over your care, ask questions, and share important information with your nurses. Nurse bedside shift report does not replace the conversations you have with your doctor.

You can invite a family member or friend to stay during nurse bedside shift report. We will only talk about your health with others when you say it is okay.

When is nurse bedside shift report?

Nurse bedside shift report happens every day between [7 and 7:30 a.m.] and [7 and 7:30 p.m.]. It usually lasts 5 minutes.

What should I expect?

During nurse bedside shift report, the nurses going off and coming on duty will:

- **Introduce themselves to you and anyone with you.** The nurse coming on duty will write his or her name and phone number on the white board in your room.
- **Invite you to take part in the nurse bedside shift report.** You should decide who else can take part with you.
- **Talk with you about your health,** including the reason you are in the hospital and what is going on with your care. The nurses will look at your medical chart.
- **Check the medicines you are taking.** The nurses will look at your IVs, injuries, and bandages. They will also follow up on any tests that were done or lab work that was ordered.
- **Ask you what could have gone better** during the last shift and what you hope to do during the next shift. For example, you may want to get out of bed or just sleep. The nurse will try to help you meet this goal.
- **Encourage you to ask questions and share your concerns.** If needed, the nurse coming on duty may come back after the bedside shift report to spend more time discussing your concerns.

What should I do?

- **Listen.** You are an important part of the health care team. We want to make sure you have complete and timely information about your care.
- **Speak up.** If you have questions or concerns, nurse bedside shift report is the perfect time to raise them.
- **Ask questions if something is confusing.** If the nurses use any words or share any information you don't understand, feel free to ask them to explain it.

- [Insert hospital name] wants to make sure that you get the best care possible.
- If you have any concerns about the quality or safety of your care during your hospital stay, please let your nurse or doctor know.
- If you are still concerned, call our [insert quality coordinator name and title] at [insert phone number].
- If nurse bedside shift report does not happen, call the nurse manager at [insert phone number].

You are invited

You are invited to take part in the nurse transition of care safety handoff. You can also invite a family member or friend to take part with you.

Nurse transition of care safety handoff happens every day between **7 and 7:30 a.m**. and **7 and 7:30p.m. It sometimes takes place at 3pm and 11pm.**

Let us know if you have any questions. We are partners in your care and are here to promote effective communication and safe care!

Thank you for choosing Santa Clara Valley Health System O'Connor Hospital! We are committed to Better Health for All!



O'CONNOR HOSPITAL
Santa Clara Valley Healthcare

Your Safety Matters to Us!

Nurse Transition of Care Safety handoff

What is it?

How can you get involved?

Being a partner in your care helps you get the best care possible in the hospital. Taking part in nurse transition of care safety handoffs is one way you can be a partner. This brochure and the poster on the wall in patient rooms explains the O'Connor Hospital nurse transition of care process.

AHRQ Agency for Healthcare Research and Quality

What is nurse transition of care safety handoff?

Nurse shift changes occur when nurses who are going off duty share information about your care with nurses coming on duty. At **O'Connor Hospital**, we want you to be involved in shift changes to make sure you get high-quality care.

Nurse bedside shift handoff is when the nurses going off and coming on duty meet to discuss your care. They will first meet outside of your room to conduct a situation-background-assessment-recommendation (SBAR) report to discuss your medical history, assessments, and current treatments. The nurses will enter your room to do a safety handoff and check on your wellbeing. This gives you a chance to meet the nurse taking over your care, ask questions, and share important information with your nurses. You can invite family members/friends to stay during nurse transition of care safety handoff.

When is nurse transition of care? (Shift Report)

Nurse transition of care happens every day between 7 and 7:30 a.m. and 7 and 7:30 p.m. and sometimes at 3pm and 11pm. The handoff usually lasts about 1-2 minutes.

What should I expect?

During the nurse transition of care safety handoff, the nurses going off and coming on duty will:

- **Introduce themselves to you and anyone with you.** The nurse coming on duty will write his or her name and phone number on the white board in your room.
- **Visually inspect and conduct a focused assessment** based on your condition that may include visually inspecting your wounds, drains, catheters, and do a quick safety check of the room. They may also check your heart rhythm on the monitor, bed alarms, and identify your needs such as position, comfort, and pain level.
- **Check the medicines you are taking.** The nurses will look at your IVs, tubing, and medications/double check high risk medications.
- **Ask you what could have gone better (Goals for next shift)**during the last shift and what you hope to do during the next shift. The nurses will try to help you meet your goals.
- **Encourage you to ask questions and share your concerns.** If needed, the nurse coming on duty may come back after the bedside shift report to spend more time discussing your concerns.

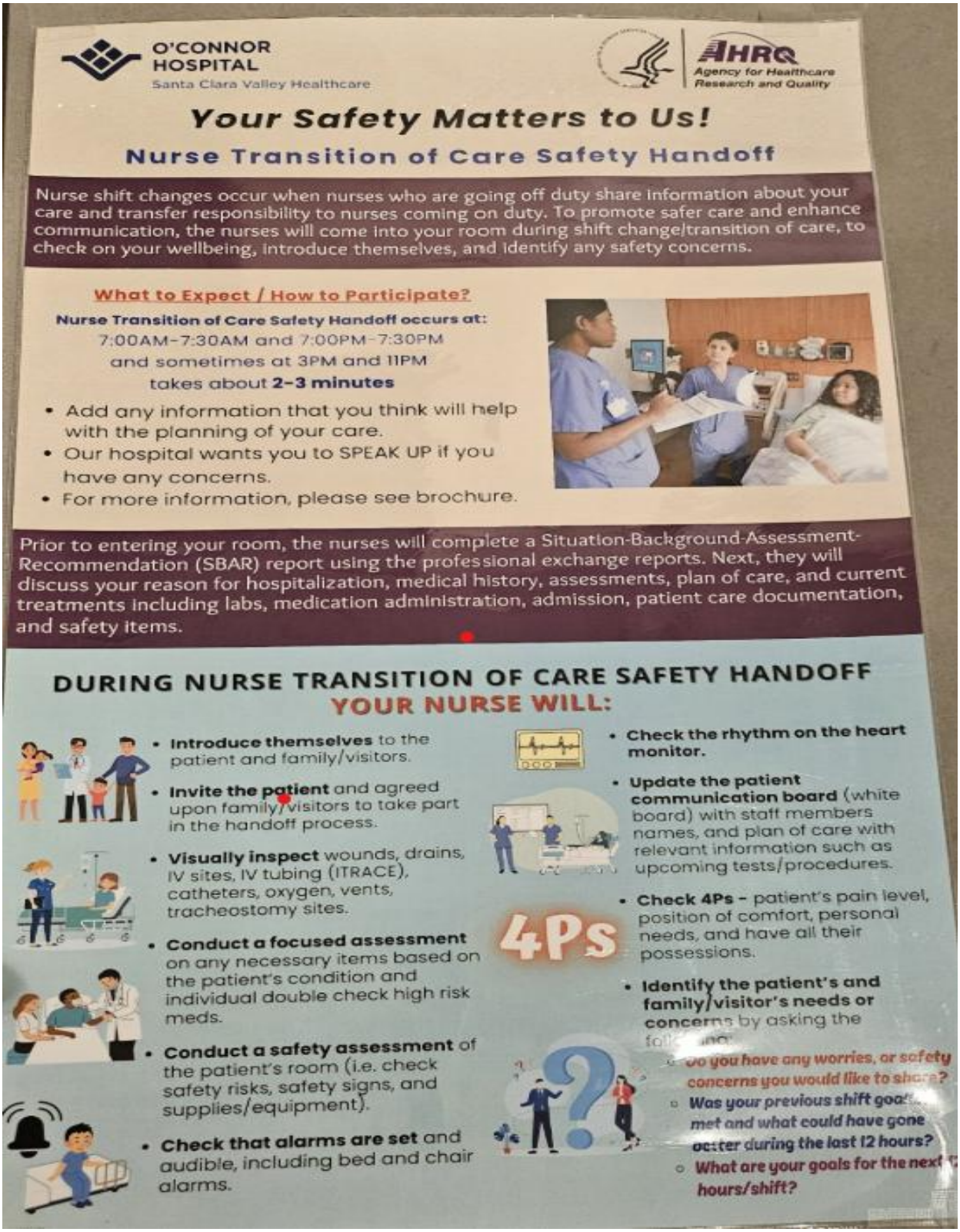
What should I do?

- **Listen.** You are an important part of the health care team. We want to make sure you have complete and timely information about your care.
- **Speak up.** If you have questions or concerns, nurse bedside shift report is the perfect time to raise them.
- **Ask questions if something is confusing.** If the nurses use any words or share any information you don't understand, feel free to ask them to explain it.

O'Connor Hospital wants to make sure that you get the best care possible.

- If you have any concerns about the quality or safety of your care during your hospital stay, please let your nurse or doctor know.
- If nurse transition of care safety handoff does not happen or you have any concerns about your care, plese feel free to notify the charge nurse or supervisor on duty.
- If you are still concerned, notify **Customer Relations Department at 408-885-4826 or email: customer.relations@hhs.sccgov.org**

Appendix G: *Modified Bedside Report Education Poster*



Appendix H: *Nurse Education Slides Using Kotter's Eight-Step Framework*

Standardized Handoff
Safe Transition of Care Between Shifts using a Modified/Partial/Blended Bedside Report



Retrieved from bedside handoff - Google Search

1

WHY is it important to have a good shift-to-shift transition of care between NURSES

23%

of medical errors in hospitals are due to communication failures during patient handoff.



Source: J. Gen. Intern. Med.

DROPSTAT

Effective and Safe Reporting at Nursing Handoff - Dropstat

- When there isn't proper communication about a patient's care between care givers patient harm can occur including:
  - Medical errors
  - Misunderstanding treatment plans
  - Missed tests and procedures
  - Failure to share critical information
  - Treatment gaps
  - Missing supplies
  - Increased infection risks
  - Malfunctioning equipment
  - Medication errors
  - Patient frustration
  - Patient anxiety
  - Erosion of trust
  - Increased risk of lawsuits
  - Violation of patient rights
  - Caregiver stress

2

Potential harm when nurses do not complete safety handoff at transition of care



- **<u>You can probably come up with examples</u>**
- Heparin checked pump but did not do ITRACE, pt was disconnected from IV, did not receive heparin.
- Incorrect Medication Rates running, medications.
- Levophed running as a secondary infusion.
- Infiltrated IV, pt's arm was swollen.
- Missed vital signs and symptoms.
- Incorrect weight entered on IV pumps (incorrect does of medications).
- Pt found down on floor—unknown how long down.
- Pt had severe neuro change not caught timely.

When nurses get report (transition of care)—the responsibility and accountability for errors discovered later may fall on the nurse assuming care. An effective handoff and consistently following the process can minimize any potential issues.

3

Why is a Standardized Approach to transition of care safety handoff recommended

Did you know?

Nurses using **standardized communication tools** during patient handoff report significantly better **communication and collaboration.**



Effective and Safe Reporting at Nursing Handoff - Dropstat



Safety First Safety Begins with Teamwork Sign - Get 10% Off Now

4

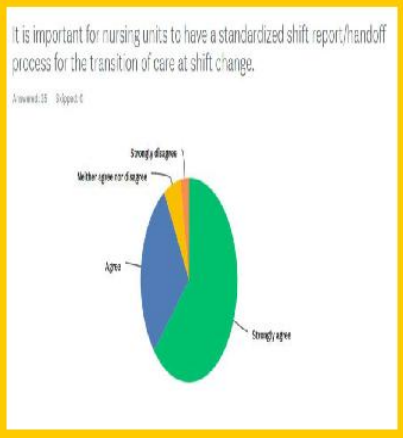
Questions from ICU Survey

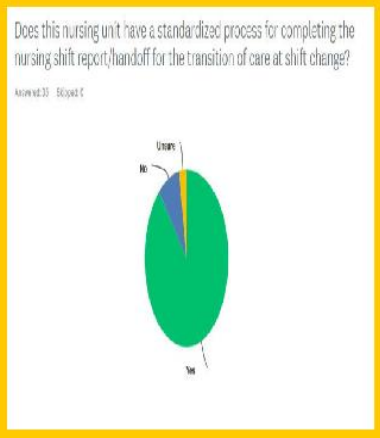
91% said it is important to have a standardized shift report

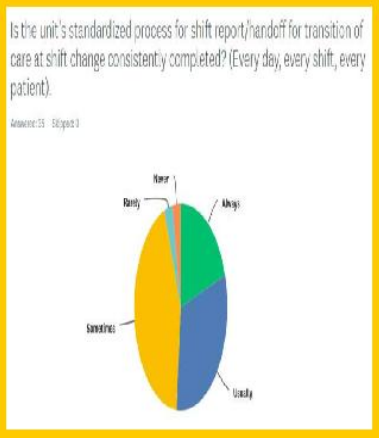
89% said unit has standardized report process

51% said Always/Usually followed

Where is the disconnect?







5





Sentinel Event Alert

A complimentary publication of The Joint Commission
Issue 58, September 12, 2017

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may be reproduced if credited to The Joint Commission. To receive by email, or to view past issues, visit www.jointcommission.org.

The Joint Commission

www.jointcommission.org

Inadequate hand-off communication

Health care professionals typically take great pride and exert painstaking effort to meet patient needs and provide the best possible care. Unfortunately, too often, this diligence and attentiveness falters when the patient is handed off, or transitioned, to another health care provider for continuing care, treatment, or services. A common problem regarding hand-offs, or hand-overs, centers on communication: expectations can be out of balance between the sender* of the information and the receiver. This misalignment is where the problem often occurs in hand-off communication.

Potential for patient harm -- from the minor to the severe -- is introduced when the receiver gets information that is inaccurate, incomplete, not timely, misinterpreted, or otherwise not what is needed. When hand-off communication fails, many factors are involved, such as health care provider training and expectations, language barriers, cultural or ethnic considerations, and inadequate, incomplete or nonexistent documentation, to name just a few.

This alert provides advice to **senders** and **receivers** of hand-off communication, including communication between caregivers within hospitals and other health care settings, as well as between hospital caregivers and those not located in a hospital. Senders are responsible for sending or transmitting patient data and releasing the care of the patient to receivers, who have been identified as those who will receive patient data and accept care of the patient. This alert makes the basic assumption that the hand-off already involves the correct receiver, sender and patient.

While it sounds simple, a high-quality hand-off is complex. Failed hand-offs are a longstanding, common problem in health care. In 2006, The Joint Commission established a National Patient Safety Goal that addressed hand-off communication. In 2010, the requirement became a standard. Provision of Care standard PC.02.02.01, element of performance (EP) 2, requires that: *The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.*

Nevertheless, gaps in communication during hand-off processes continue to exist, thereby increasing patient safety risk.[1,2] The problem is compounded by the high frequency of hand-offs in health care, especially in hospitals. It's estimated that a typical teaching hospital may experience more than 4,000 hand-offs every day.[3] However, sometimes hand-offs are conducted too casually, when they should be structured and focused to ensure continuity of care.

* For the purposes of this alert, the sender is the individual who provides the clinical information to the receiving caregiver.

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Published by the Department of Corporate Communications

A Complimentary Publication of The Joint Commission Issue 58, September 12, 2017

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Build a guiding coalition



We Can & We Will Let's Make It Happen! Best Team Ever notebook: Cute Lined Notebook, Team Motivational Gifts for Employees... Thank You Gift For Team, Employees, Coworkers... | Teamwork motivational, Motivational quotes for 9798620598380: Amazon.com: Books

Let's work together to determine an approach to nurse transition of care shift-to-shift handoff that supports nurses and promotes patient safety and satisfaction

- Guiding Coalition
  - ICU Shared Leadership Team
  - ICU Registered Nurses
  - ICU Management Team
  - Hospital Administration
  - AHRQ
  - The Joint Commission
  - Regulatory Agencies
  - Anyone who wants safer care, better communication, and a report process that is consistently completed.
  - Each one of us can make a difference! Let's solve this issue together!

7



Turning Your Future Vision into Reality | Convenience Store Resource

Goals of Project

- Standardize Handoff to improve patient safety.
- Implement modified/blended/partial/hybrid bedside report handoff to see if it is an effective alternative to full bedside report.
- Validate that part of handoff report can be completed safely outside of room and part of handoff report can be completed inside room.
- It is important to complete safety handoff and patient experience part of report inside the patient's room.
- Improve nurse satisfaction, teamwork, and collaboration.
- Develop a model that can be used in all of O'Connor Hospital and potentially the entire enterprise.
- Demonstrate that modified bedside report is a more natural way to complete report for both patients and nurses.

8

How Can We Achieve these Goals

Get Involved, Play an Active Role

- **Patient/family Involvement:** Empower them to become Active Members in Care by educating them on process, handing out brochure, highlighting wall poster.
- **Staff involvement:** It will take each and everyone to achieve this goal. We want to improve nurse satisfaction with the handoff process.
- **Understand the changes:** and how we can promote an effective handoff process. Review slides, poster, and understand how the process is crucial to patient safety and satisfaction.
- **Provide feedback,** suggestions that you think will help the unit standardize handoff.
- **Communicate with Shared Leadership Members** to bring up concerns at their scheduled meetings.
- **AHRQ Handoff Tool:** Use of the modified version of the standardized tool created by the AHRQ.

9

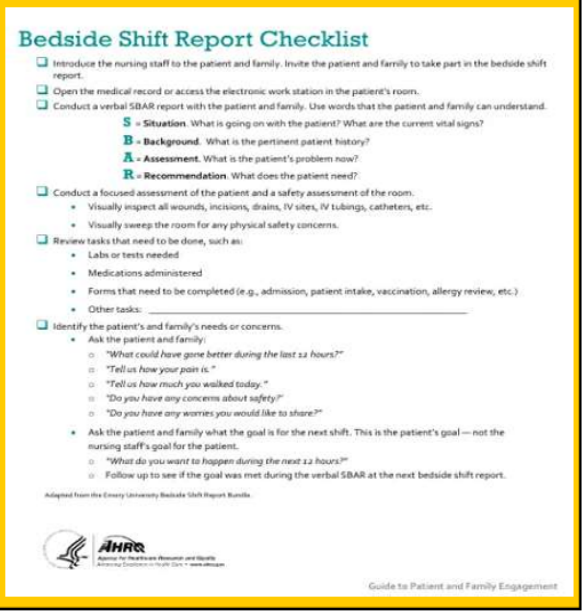
Overview of AHRQ

- The AHRQ stands for the Agency for Healthcare Research and Quality.
- It is part of the US Department of Health and Human Services (HHS)
- The AHRQ' primary mission is to improve the quality, safety, efficiency, and effectiveness of healthcare in the United States.
- The AHRQ funds and conducts research to improve healthcare practices and policies.
- The AHRQ develops tools, guidelines, and resources to help healthcare providers and organizations implement evidence-based practices.

10

AHRQ Bedside Shift Report and Handoff Checklist

- Standardized communication tool to enhance accuracy
- Checklist items for comprehensive handoff (patient's condition, medications, upcoming tests)
- Ensure no critical information is missed
- Prevent communication breakdowns between shifts
- Ensure all vital information is passed along to the oncoming nurse
- Promote patient centered care and engagement by involving patient in their care plan.
- Greater patient satisfaction with increased clarity about their care plan
- The AHRQ recommends the items on the checklist are completed at each transition of care/handoff.



Bedside Shift Report Checklist

- ❑ Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report.
- ❑ Open the medical record or access the electronic work station in the patient's room.
- ❑ Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.
  - **S** = **Situation**. What is going on with the patient? What are the current vital signs?
  - **B** = **Background**. What is the pertinent patient history?
  - **A** = **Assessment**. What is the patient's problem now?
  - **R** = **Recommendation**. What does the patient need?
- ❑ Conduct a focused assessment of the patient and a safety assessment of the room.
  - Visually inspect all wounds, incisions, drains, IV sites, IV tubings, catheters, etc.
  - Visually sweep the room for any physical safety concerns.
- ❑ Review tasks that need to be done, such as:
  - Labs or tests needed
  - Medications administered
  - Forms that need to be completed (e.g., admission, patient intake, vaccination, allergy review, etc.)
  - Other tasks: _____
- ❑ Identify the patient's and family's needs or concerns.
  - Ask the patient and family:
    - *"What could have gone better during the last 12 hours?"*
    - *"Tell us how your pain is."*
    - *"Tell us how much you walked today."*
    - *"Do you have any concerns about safety?"*
    - *"Do you have any worries you would like to share?"*
  - Ask the patient and family what the goal is for the next shift. This is the patient's goal — not the nursing staff's goal for the patient.
    - *"What do you want to happen during the next 12 hours?"*
    - Follow up to see if the goal was met during the verbal SBAR at the next bedside shift report.

Adapted from the Emory University Bedside Shift Report Bundle.

AHRQ Agency for Healthcare Research and Quality

Guide to Patient and Family Engagement

11

Modified/Partial/Blended/Hybrid Bedside Report

- The modified report involves a combination of bedside and off-bedside reporting where some part of the report is done at the bedside while other parts of report take place outside of room away from the bedside.
- Enhances Communication
- Fasters transitions of care, especially if using electronic health record to display relevant information during report.
- Improves patient satisfaction: It empowers patients and makes them feel respected and informed.
- Enhances the quality of care
- Enhances safety standards
- Improves communication
- Reduces interruptions/distractions
- Supports family and patient involvement
- Reduces handoff errors.
- Supports a culture of transparency, accountability, and collaboration.
- Involves the patient/family in goal setting and care planning

12

What is Completed inside the Room, What is Completed Outside the Room Standardization and Consistency Matters!

Modified Bedside Report Observation Checklist (Modified AHRQ)

Date:_____ Start Time:_____ Stop Time:_____ Total Time:_____

Safety Handoff (Patient's Room)	Done/Not Done	Nurse Report (Nurses Station)	Done/Not Done
Invite the patient/family to take part in the report	Done/Not Done Bedside/Nurses Station	**Opens the medical record** (Checks Active Orders)	Done/Not Done Bedside/Nurses Station
Introduces nursing staff to the patient and family	Done/Not Done Bedside/Nurses Station	**Uses Professional Exchange Reports** in electronic medical record	Done/Not Done Bedside/Nurses Station
Updates the whiteboard & patient/family on plan of care	Done/Not Done Bedside/Nurses Station	**Conduct a verbal SBAR** report/handoff.	Done/Not Done Bedside/Nurses Station
Conducts a focused assessment (Checks high risk meds) What:	Done/Not Done Bedside/Nurses Station	**Situation:** Discuss what is going on with the patient: DX, current condition, allergies.	Done/Not Done Bedside/Nurses Station
Visually inspects wounds, incisions, drains, IV sites, IV tubing dated, ITRACE, curos caps, dressings, Foley, etc. Other:	Done/Not Done Bedside/Nurses Station	**Background:** Discusses the pertinent patient history: medications, health, surgical histories, comorbidities, treatments, tests, precautions.	Done/Not Done Bedside/Nurses Station
Visually sweeps the room for safety concerns (physical safety, bed alarms, equipment, supplies, safety/isolation signs)	Done/Not Done Bedside/Nurses Station	**Assessment:** What is the patient's problem now: Assessment of systems, any recent changes in condition/Tx, last VS, pain, lines/drains, immediate concerns, stability.	Done/Not Done Bedside/Nurses Station
Checks the 4 Ps: Pain, position, personal needs, high risk possessions: hearing aids, glasses, dentures, phones	Done/Not Done Bedside/Nurses Station	**Recommendation:** What does the patient need? Anticipated change in condition or treatment. What to watch for in next interval of care, goals, plans, special needs, potential problems.	Done/Not Done Bedside/Nurses Station
Checks heart rhythm on monitor	Done/Not Done Bedside/Nurses Station	**Review tasks**: **Labs or tests**	Done/Not Done Bedside/Nurses Station
Ask patient/family: Were your previous goal(s) met? What could have gone better?	Done/Not Done Bedside/Nurses Station	**Reviews tasks**: **Medication Administered**	Done/Not Done Bedside/Nurses Station
Ask the patient/family: "Do you have any worries, or safety concerns you would like to share?"	Done/Not Done Bedside/Nurses Station	**Reviews tasks: admission, PTA meds, restraints, surgical/dialysis checklist, CHG/Theraworx**, etc.	Done/Not Done Bedside/Nurses Station
Ask the patient/family what are your goals for the next shift	Done/Not Done Bedside/Nurses Station	**Documents** SBAR patient hand-off communication in HER preferably under Report Given to Navigator.	Done/Not Done Bedside/Nurses Station

Notes/Observations:

13

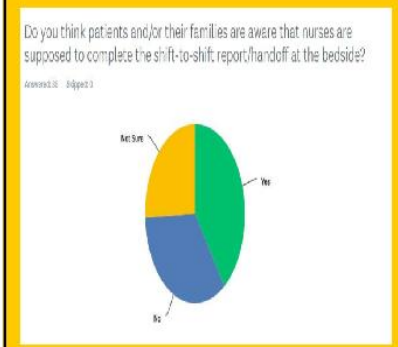
Patient and Family Involvement in Transition of care (Report)

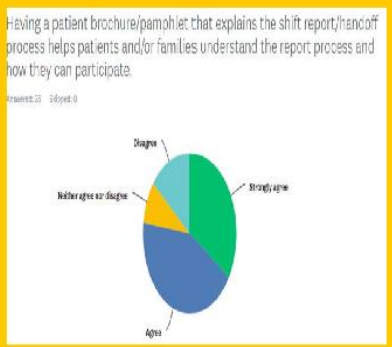
ICU Survey

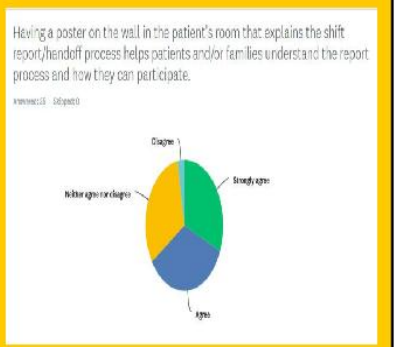
40% responded patients/families are aware of bedside report

66% responded having a poster on wall in room would help patients/families understand report process and how they can participate

77% responded having a brochure would help patients/families understand the report process and how they can participate

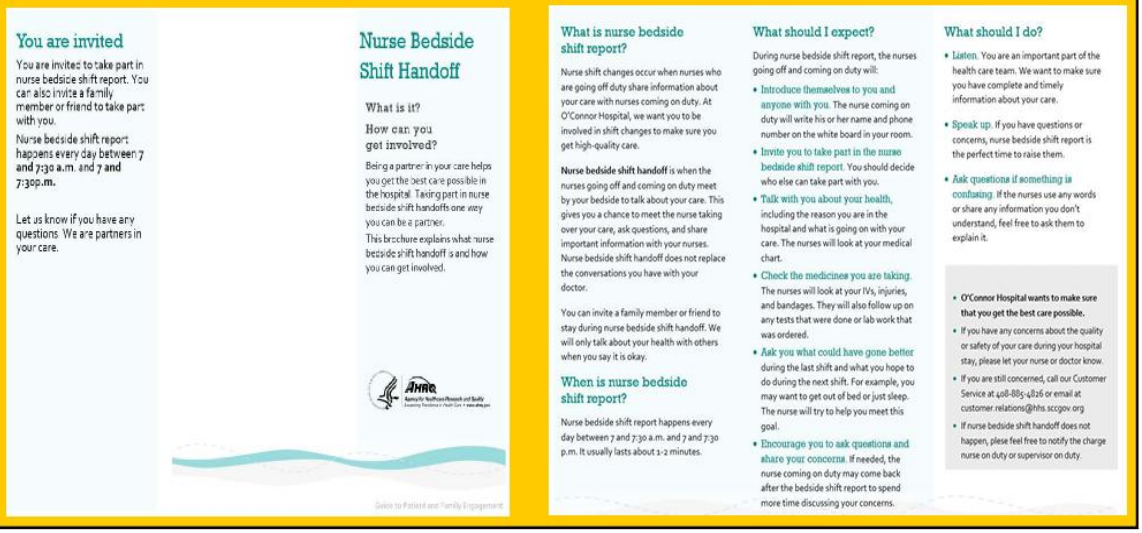






14

Patient/Family Education Brochure Available at Front desk to explain process and provide more information on transition of care process



You are invited

You are invited to take part in nurse bedside shift report. You can also invite a family member or friend to take part with you.

Nurse bedside shift report happens every day between 7 and 7:30 a.m. and 7 and 7:30p.m.

Let us know if you have any questions. We are partners in your care.

Nurse Bedside Shift Handoff

What is it?

How can you get involved?

Being a partner in your care helps you get the best care possible in the hospital. Taking part in nurse bedside shift handoffs one way you can be a partner.

This brochure explains what nurse bedside shift handoff is and how you can get involved.

AHRQ Agency for Healthcare Research and Quality

Guide to Patient and Family Engagement

What is nurse bedside shift report?

Nurse shift changes occur when nurses who are going off duty share information about your care with nurses coming on duty. At O'Connor Hospital, we want you to be involved in shift changes to make sure you get high-quality care.

Nurse bedside shift handoff is when the nurses going off and coming on duty meet by your bedside to talk about your care. This gives you a chance to meet the nurse taking over your care, ask questions, and share important information with your nurses. Nurse bedside shift handoff does not replace the conversations you have with your doctor.

You can invite a family member or friend to stay during nurse bedside shift handoff. We will only talk about your health with others when you say it is okay.

When is nurse bedside shift report?

Nurse bedside shift report happens every day between 7 and 7:30 a.m. and 7 and 7:30 p.m. It usually lasts about 1-2 minutes.

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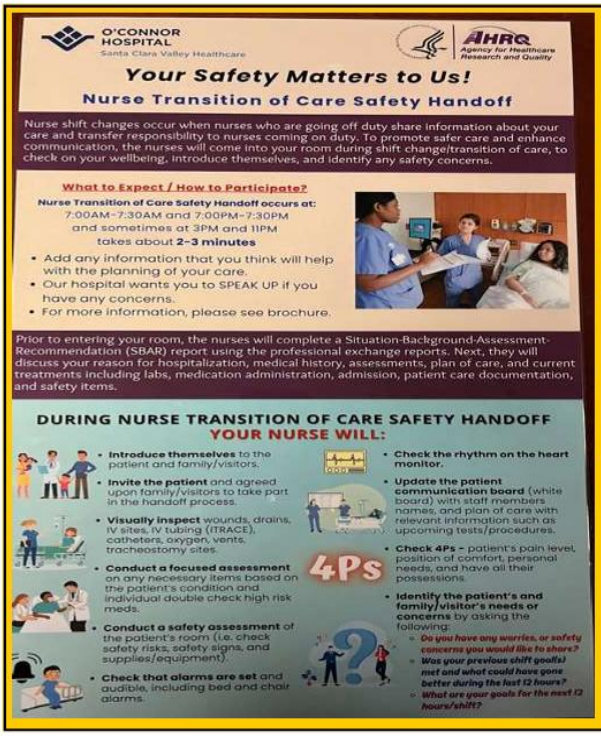
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- Invite you to take part in the nurse bedside shift report. You should decide who else can take part with you.
- Talk with you about your health, including the reason you are in the hospital and what is going on with your care. The nurses will look at your medical chart.
- Check the medicines you are taking. The nurses will look at your IVs, injuries, and bandages. They will also follow up on any tests that were done or lab work that was ordered.
- Ask you what could have gone better during the last shift and what you hope to do during the next shift. For example, you may want to get out of bed or just sleep. The nurse will try to help you meet this goal.
- Encourage you to ask questions and share your concerns. If needed, the nurse coming on duty may come back after the bedside shift report to spend more time discussing your concerns.

What should I do?

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- **O'Connor Hospital wants to make sure that you get the best care possible.**
- If you have any concerns about the quality or safety of your care during your hospital stay, please let your nurse or doctor know.
- If you are still concerned, call our Customer Service at 408-885-4826 or email at customer.relations@hhs.sccgov.org
- If nurse bedside shift handoff does not happen, plese feel free to notify the charge nurse on duty or supervisor on duty.

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O'CONNOR HOSPITAL
Santa Clara Valley Healthcare

AHRQ Agency for Healthcare Research and Quality

Your Safety Matters to Us!

Nurse Transition of Care Safety Handoff

Nurse shift changes occur when nurses who are going off duty share information about your care and transfer responsibility to nurses coming on duty. To promote safer care and enhance communication, the nurses will come into your room during shift change/transition of care, to check on your wellbeing, introduce themselves, and identify any safety concerns.

What to Expect / How to Participate?

Nurse Transition of Care Safety Handoff occurs at:
7:00AM-7:30AM and 7:00PM-7:30PM
and sometimes at 3PM and 11PM
takes about **2-3 minutes**

- Add any information that you think will help with the planning of your care.
- Our hospital wants you to SPEAK UP if you have any concerns.
- For more information, please see brochure.

Prior to entering your room, the nurses will complete a Situation-Background-Assessment-Recommendation (SBAR) report using the professional exchange reports. Next, they will discuss your reason for hospitalization, medical history, assessments, plan of care, and current treatments including labs, medication administration, admission, patient care documentation, and safety items.

DURING NURSE TRANSITION OF CARE SAFETY HANDOFF YOUR NURSE WILL:

- **Introduce themselves** to the patient and family/visitors.
- **Invite the patient** and agreed upon family/visitors to take part in the handoff process.
- **Visually inspect** wounds, drains, IV sites, IV tubing (ITRACE), catheters, oxygen, vents, tracheostomy sites.
- **Conduct a focused assessment** on any necessary items based on the patient's condition and individual double check high risk meds.
- **Conduct a safety assessment** of the patient's room (i.e. check safety risks, safety signs, and supplies/equipment).
- **Check that alarms are set** and audible, including bed and chair alarms.
- **Check the rhythm on the heart monitor.**
- **Update the patient communication board** (white board) with staff members names, and plan of care with relevant information such as upcoming tests/procedures.
- **Check 4Ps -** patient's pain level, position of comfort, personal needs, and have all their possessions.
- **Identify the patient's and family/visitor's needs or concerns** by asking the following:
  - *Do you have any worries, or safety concerns you would like to share?*
  - *Was your previous shift goal(s) met and what could have gone better during the last 12 hours?*
  - *What are your goals for the next 12 hours/shift?*

4Ps

How do I give a modified beside transition of care report?

- **There is a poster in every patient's room. Follow the poster**
- **Step 1:** Outside of Room open Professional Exchange Report (Example on next slide).
- **Step 2:** Complete SBAR Report.
- **Step 3:** Review labs/tests, medications, tasks including admission, CHG/Theraworx, restraints, ensure tasks completed.
- **Step 4:** Document SBAR Handoff (Ent. # 0120)

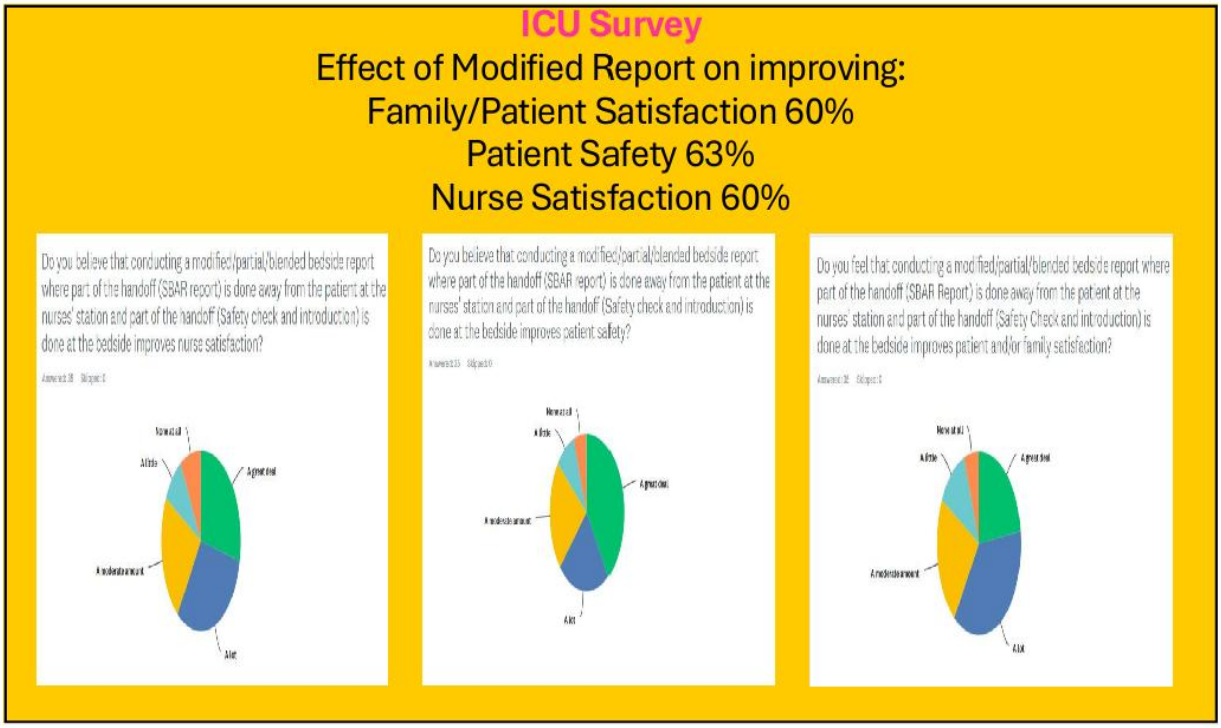


- **Step 5:** Enter Room and complete the safety handoff using guide at bottom of poster. (Introduce oncoming nurse, invite patient to participate, visually inspect, conduct a focused assessment, conduct a safety assessment, ensure alarms are set, check tele rhythm, update white board, check 4Ps, Identify patient/family concerns.

16


Professional Exchange Report
has a wealth of information on one page instead of jumping around to multiple pages(26% use)
It should be opened & used consistently during report to avoid missed information and promote effective communication
I use the Professional Exchange Report in the electronic medical record when completing a SBAR (Situation-Background-Assessment-Recommendation) report/handoff for the transition of care between shifts.
Summary
Index
Adult SBAR Handoff
Blood Transfusion
Core Measures Checklist
Active Orders +
Overview
FS
Flowsheet Compliance
Prof Exchange Report
Problem List
Never Reviewed
Spokesperson,Password & Caregiver - Update in Admission>Gen. Info
Treatment Team
Dysphagia Screening
Timeline
Respiratory
I/O
Lab Orders
(From admission, onward)
Nursing Assessments
SBAR
Nursing Activities and Treatment
(From admission, onward)
Psychosocial/Environmental
Scales and Screens
Sticky Note - Nursing follow up
My Care Plans
Planning for My Discharge
Education Titles
Safety Interventions
Active Order Sets
Medications
Selected Labs
(Last result from the past 72 hours)
Vital Signs
Imaging
(Last 72 hours)
Lines/Drains/Airways
Inpatient Falls
Diet Orders
POCT Orders
(From admission, onward)

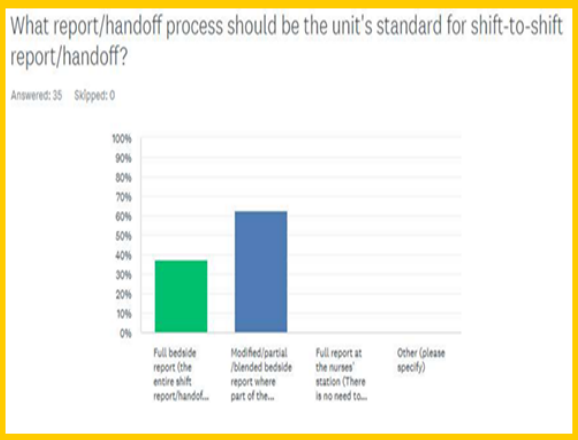
17

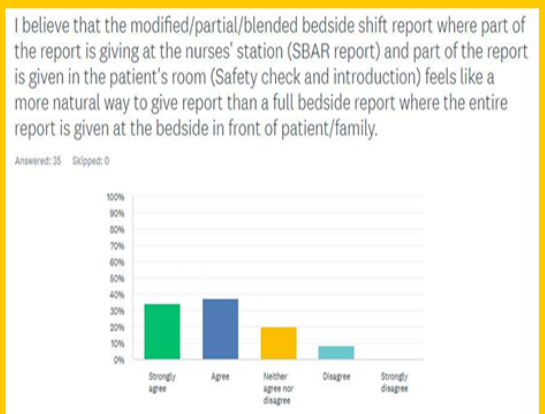

ICU Survey
Effect of Modified Report on improving:
Family/Patient Satisfaction 60%
Patient Safety 63%
Nurse Satisfaction 60%
Do you believe that conducting a modified/partial/blended bedside report where part of the handoff (SBAR report) is done away from the patient at the nurses' station and part of the handoff (Safety check and introduction) is done at the bedside improves nurse satisfaction?
Do you believe that conducting a modified/partial/blended bedside report where part of the handoff (SBAR report) is done away from the patient at the nurses' station and part of the handoff (Safety check and introduction) is done at the bedside improves patient safety?
Do you feel that conducting a modified/partial/blended bedside report where part of the handoff (SBAR Report) is done away from the patient at the nurses' station and part of the handoff (Safety Check and introduction) is done at the bedside improves patient and/or family satisfaction?

18

ICU Survey

63% thought Modified Bedside Report should be the unit's standardized approach to nurse transition of care (37% Full)
71% Reported Modified Bedside Reports Feels Like a more Natural Way to Give Report





19

What are we doing? Let's Act!

- **Why:** To promote effective communication, safety, and enhance nurse and patient satisfaction and ensure we are in alignment with Enterprise Policy #0120. There are many benefits to nurses for conducting a modified bedside report.
- **What:** Use a modified bedside report where the SBAR section of report is given outside of patient room. Nursing Station Okay. Safety handoff, focused assessment, introduction, update whiteboard done inside room. Consistency is key to achieving results.
- **Who:** All Nurses (Oncoming/off going nurses).
- **When:** Completed at Shift Change when the transition of care and responsibility takes place. Starting Monday 3/31 education will begin. Monday 4/7 rollout.
- **Where:** Review Professional Exchange Report and give SBAR handoff outside of room and safety check and patient experience inside of room.
- **How:** Complete SBAR outside of room to focus on accurate communication/minimize distractions and then go in room for 1-2 minutes to complete focused assessment, update whiteboards, and ask patient/family about plan of care goals.
- **What else:** There is a poster in the patients' rooms, break rooms, shared leadership board, and huddle board to remind you of the steps.

The process is simple and easy but makes an incredible difference.

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Let's Aim for Some Short-Term Wins



- Education Rollout (3/31/25: Huddle message, email slides, posters 4/7/25 Go live)
- Based off observations: Areas for improvement: Focus on using professional exchange report, documenting SBAR handoff, introductions/update whiteboards, ask patients about their goals/care, 2 Person skin handoff.
- Continue with weekly bedside report observations.
- Provide feedback.
- Continue to improve the number of items completed on the AHRQ report checklist.
- Meet monthly at shared leadership meetings to discuss what's going well, what we can do better (PDSA).
- Celebrate successes!

21

Use QR Code or Link Below to Provide Feedback at Anytime about the Modified Bedside Report Process/project



https://www.surveymonkey.com/r/8CJ389T

22

Appendix I: *AHRQ Bedside Shift Report Checklist:*

Bedside Shift Report Checklist

- ☐ Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report. Bedside
- ☐ Open the medical record or access the electronic work station in the patient's room. Nursing Station
- ☐ Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand. Nursing Station
  - **S** = **Situation**. What is going on with the patient? What are the current vital signs?
  - **B** = **Background**. What is the pertinent patient history?
  - **A** = **Assessment**. What is the patient's problem now?
  - **R** = **Recommendation**. What does the patient need?
- ☐ Conduct a focused assessment of the patient and a safety assessment of the room. Bedside
  - Visually inspect all wounds, incisions, drains, IV sites, IV tubings, catheters, etc.
  - Visually sweep the room for any physical safety concerns. Bedside
- ☐ Review tasks that need to be done, such as: Nursing Station
  - Labs or tests needed
  - Medications administered
  - Forms that need to be completed (e.g., admission, patient intake, vaccination, allergy review, etc.)
  - Other tasks: _____
- ☐ Identify the patient's and family's needs or concerns.
  - Ask the patient and family: Bedside
    - *"What could have gone better during the last 12 hours?"*
    - *"Tell us how your pain is."*
    - *"Tell us how much you walked today."*
    - *"Do you have any concerns about safety?"*
    - *"Do you have any worries you would like to share?"*
  - Ask the patient and family what the goal is for the next shift. This is the patient's goal — not the nursing staff's goal for the patient. Bedside
    - *"What do you want to happen during the next 12 hours?"*
    - Follow up to see if the goal was met during the verbal SBAR at the next bedside shift report.

Adapted from the Emory University Bedside Shift Report Bundle.

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Guide to Patient and Family Engagement

Appendix J: *Modified Bedside Report Observation Checklist based off AHRQ and Hospital Policies*

Modified Bedside Report Observation Checklist (Modified AHRQ)



Date: Start Time: Stop Time: Total Time:

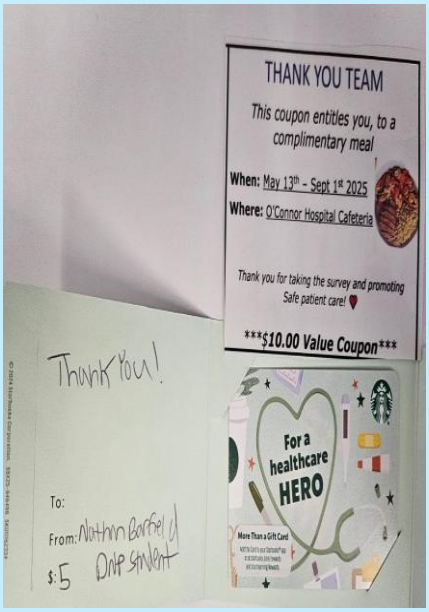
Safety Handoff (Patient's Room)	Done/Not Done	Nurse Report (Nurses Station)	Done/Not Done
Invite the patient/family to take part in the handoff	Done/Not Done/NA Bedside/Nurses Station	**Opens the medical record** (Checks Active Orders)	Done/Not Done Bedside/Nurses Station
Introduces nursing staff to the patient and family	Done/Not Done/NA Bedside/Nurses Station	**Uses Professional Exchange Reports** in electronic medical record	Done/Not Done Bedside/Nurses Station
Updates the whiteboard & patient/family on plan of care	Done/Not Done/NA Bedside/Nurses Station	**Conduct a verbal SBAR** report/handoff.	Done/Not Done Bedside/Nurses Station
Conducts a focused assessment (Checks high risk meds) What:	Done/Not Done/NA Bedside/Nurses Station	**Situation:** Discuss what is going on with the patient: DX, current condition, allergies.	Done/Not Done Bedside/Nurses Station
Visually inspects wounds, incisions, drains, IV sites, IV tubing dated, ITRACE, curos caps, dressings, Foley, etc. Other:	Done/Not Done/NA Bedside/Nurses Station	**Background:** Discusses the pertinent patient history: medications, health, surgical histories, comorbidities, treatments, tests, precautions.	Done/Not Done Bedside/Nurses Station
Visually sweeps the room for safety concerns (physical safety, bed alarms, equipment, supplies, safety/isolation signs)	Done/Not Done/NA Bedside/Nurses Station	**Assessment:** What is the patient's problem now: Assessment of systems, any recent changes in condition/Tx, last VS, pain, lines/drains, immediate concerns, stability.	Done/Not Done Bedside/Nurses Station
Checks the 4 Ps: Pain, position, personal needs, high risk possessions: hearing aids, glasses, dentures, phones	Done/Not Done/NA Bedside/Nurses Station	**Recommendation:** What does the patient need? Anticipated change in condition or treatment. What to watch for in next interval of care, goals, plans, special needs, potential problems.	Done/Not Done Bedside/Nurses Station
Checks heart rhythm on monitor	Done/Not Done/NA Bedside/Nurses Station	**Review tasks: Labs or tests**	Done/Not Done Bedside/Nurses Station
Ask patient/family: Were your previous goal(s) met? What could have gone better?	Done/Not Done/NA Bedside/Nurses Station	**Reviews tasks: Medication Administered**	Done/Not Done Bedside/Nurses Station
Ask the patient/family: "Do you have any worries, or safety concerns you would like to share?"	Done/Not Done/NA Bedside/Nurses Station	**Reviews tasks: admission, PTA meds, restraints, surgical/dialysis checklist, CHG/Theraworx,** etc.	Done/Not Done Bedside/Nurses Station
Ask the patient/family what are your goals for the next shift	Done/Not Done/NA Bedside/Nurses Station	**Documents** SBAR patient hand-off communication in EHR preferably under Report Given to Navigator.	Done/Not Done Bedside/Nurses Station

Notes/Observations:

Appendix K: *Badge Reel, Gift Cards, Dry Eraser to Update Whiteboards*

Small tokens of appreciation for completing Survey







Appendix L: *Staff Nurse Pre/Post Survey*

Nurses' Feedback on Shift-to-Shift Reports/Handoffs (Pre)

Your Feedback Matters! Thank You for Making a Difference!

- Thank you for participating in this anonymous, voluntary survey.
- Your feedback is needed to better understand the organization/unit's shift-to-shift report/handoff process.
- The survey has 36 required multiple-choice questions and two optional comment questions.
- It is estimated to take approximately ten minutes to complete.
- The survey is being conducted as part of a DNP quality improvement project.
- To help us better understand the handoff/report process, please answer the questions honestly and to the best of your knowledge (There are no right or wrong answers).
- Thank you for your time and feedback! We appreciate your help!

* 1. How long have you been practicing as a registered nurse?

- ◯ Less than 1 year
- ◯ 1-5 years
- ◯ 6-10 years
- ◯ 11-15 years
- ◯ 16-20 years
- ◯ 21-30 years
- ◯ Greater than 30 years

* 2. It is important for nursing units to have a **standardized** shift report/handoff process for the transition of care at shift change.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

* 3. Does this nursing unit have a **standardized process** for completing the nursing shift report/handoff for the transition of care at shift change?

- ◯ Yes
- ◯ No
- ◯ Unsure

* 4. Is the unit's **standardized** process for shift report/handoff for transition of care at shift change **consistently** completed? **(Every day, every shift, every patient).**

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 5. During shift change, when completing the shift-to-shift report/handoff, I invite the patient and/or family to take part?

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never



* 6. Do you think patients and/or their families are aware that nurses are supposed to complete the shift-to-shift report/handoff at the bedside?

- ◯ Yes
- ◯ No
- ◯ Not Sure

* 7. Having a poster on the wall in the patient's room that explains the shift report/handoff process helps patients and/or families understand the report process and how they can participate.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

* 8. Having a patient brochure/pamphlet that explains the shift report/handoff process helps patients and/or families understand the report process and how they can participate.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

* 9. During shift change, when completing the shift-to-shift report/handoff, I introduce the oncoming nurse to the patient and family.

- ◯ Always
- ◯ Often
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 10. I follow the **SBAR** (Situation, Background, Assessment, Recommendation) format during shift change when completing the shift-to-shift report/handoff?

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 11. During shift change when completing the shift-to-shift report/handoff, I review tasks such as medication administration (what was given/needs to be given).

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 12. During shift change when completing the shift-to-shift report/handoff, I review tasks such as labs and tests that were done or need to be done.

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 13. During shift change when completing the shift-to-shift report/handoff, I review tasks that were done or need to be done, including required assessments (i.e. restraints, admissions, pre-surgery checklists, Theraworx/CHG bath, prior to admission medications, belongings, etc.)

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never



* 14. On average, how long does it take to complete the **SBAR (Situation-Background-Assessment-Recommendation) report/handoff process** where the oncoming nurse is updated about the patient's condition for **one patient.**

- ◯ Less than 1 minutes
- ◯ 1-2 minutes
- ◯ 2-3 minutes
- ◯ 3-4 minutes
- ◯ 4-5 minutes
- ◯ 5-6 minutes
- ◯ 6-7 minutes
- ◯ 7-8 minutes
- ◯ 8-9 minutes
- ◯ 9-10 minutes
- ◯ Greater than 10 minutes
- ◯ Not completed/does not happen

* 15. I use the **Professional Exchange Report** in the electronic medical record when completing a SBAR (Situation-Background-Assessment-Recommendation) report/handoff for the transition of care between shifts.

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 16. I **document in the patient's electronic medical record** that an SBAR handoff/report was completed (received from/given to) to transfer care at shift change.

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 17. I **visually inspect** wounds, incisions, drains, IV sites, IV tubing, catheters, I-TRACE, oxygen, vents, tracheostomy, etc. during the shift-to-shift report/handoff between nurses.

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 18. I **conduct a focused assessment** of the patient during shift change when completing the shift-to-shift report/handoff?

- ◯ Always
- ◯ Often
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 19. If a patient is on telemetry, I **check the telemetry rhythm** during shift change when completing the shift-to-shift report/handoff?

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never



* 20. I **conduct a safety assessment of the patient's room** (visually sweep the room for any physical safety concerns, equipment, supplies) during shift change when completing the shift-to-shift report/handoff?

- ◯ Always
- ◯ Often
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 21. During shift change, when completing the shift-to-shift report, I **update the patient's whiteboard** with relevant information (update communication board in patients' rooms with key staff members names, plan of care, questions, etc.).

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 22. During shift change, when completing the shift-to-shift report/handoff, I identify the patient's and/or family's concerns by asking, "**Do you have any worries or safety concerns you would like to share?**"

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never



* 23. During shift change, when completing the shift-to-shift report/handoff, I identify the patient's and family's needs or concerns by asking, "**Were your previous shift goal(s) met? What could have gone better during the last 12 hours?**"

- ◯ Always
- ◯ Usually
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 24. During shift change, when completing the shift-to-shift report/handoff, I ask the patient and/or family, "**What are your goals for this shift/the next 12 hours?**"

- ◯ Always
- ◯ Often
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

* 25. Are you familiar with the **modified/partial/blended bedside report?**

- ◯ Extremely familiar
- ◯ Very familiar
- ◯ Somewhat familiar
- ◯ Not so familiar
- ◯ Not at all familiar

* 26. Are you familiar with the Agency for Healthcare Research and Quality's (AHRQ) Bedside Shift Report Checklist?

- ◯ Extremely familiar
- ◯ Very familiar
- ◯ Somewhat familiar
- ◯ Not so familiar
- ◯ Not at all familiar

* 27. Do you feel that conducting the **full** bedside shift report (Entire shift report is given Infront of patient/family) at the bedside increases **patient and/or family satisfaction?**

- ◯ A great deal
- ◯ A lot
- ◯ A moderate amount
- ◯ A little
- ◯ None at all

* 28. Do you feel that conducting a **modified/partial/blended** bedside report where part of the handoff (SBAR Report) is done away from the patient at the nurses' station and part of the handoff (Safety Check and introduction) is done at the bedside improves **patient and/or family satisfaction?**

- ◯ A great deal
- ◯ A lot
- ◯ A moderate amount
- ◯ A little
- ◯ None at all

* 29. Do you believe that conducting **full** bedside shift reports (entire report is given infront of patient/family) at the bedside improves **patient safety?**

- ◯ A great deal
- ◯ A lot
- ◯ A moderate amount
- ◯ A little
- ◯ None at all



* 30. Do you believe that conducting a **modified/partial/blended** bedside report where part of the handoff (SBAR report) is done away from the patient at the nurses' station and part of the handoff (Safety check and introduction) is done at the bedside improves **patient safety?**

- ◯ A great deal
- ◯ A lot
- ◯ A moderate amount
- ◯ A little
- ◯ None at all

* 31. Do you believe that conducting a **modified/partial/blended** bedside report where part of the handoff (SBAR report) is done away from the patient at the nurses' station and part of the handoff (Safety check and introduction) is done at the bedside improves **nurse satisfaction?**

- ◯ A great deal
- ◯ A lot
- ◯ A moderate amount
- ◯ A little
- ◯ None at all

* 32. Do you believe that conducting **full** bedside shift reports (Entire report is given infront of patient/family) improves **nurse satisfaction?**

- ◯ A great deal
- ◯ A lot
- ◯ A moderate amount
- ◯ A little
- ◯ None at all



* 33. I believe that the modified/partial/blended bedside shift report where part of the report is giving at the nurses' station (SBAR report) and part of the report is given in the patient's room (Safety check and introduction) feels like **a more natural way to give report** than a full bedside report where the entire report is given at the bedside in front of patient/family.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree

* 34. I have adequate training and/or resources to complete a modified/blended/partial bedside shift handoff?

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree nor disagree
- ◯ Disagree
- ◯ Strongly disagree
- ◯ Other (please specify)

* 35. What report/handoff process **should be the unit's standard for shift-to-shift report/handoff?**

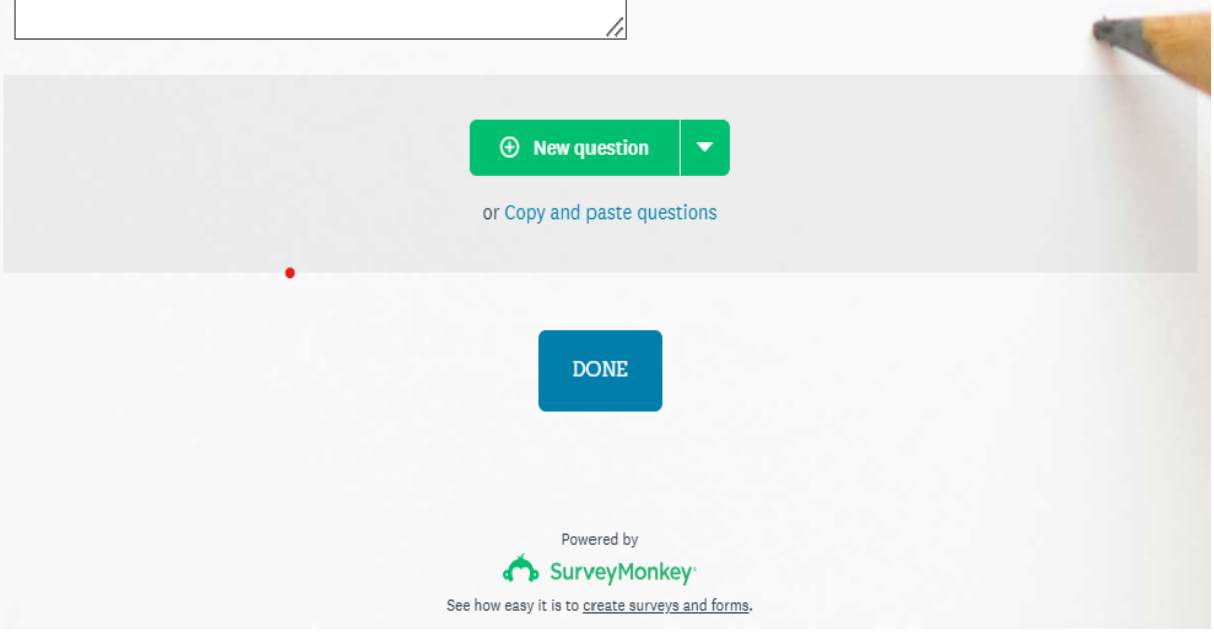
- ◯ **Full bedside report** (the entire shift report/handoff is done at the bedside in front of the patient and/or family). No part of the report is done at the nurses' station/outside of patient's room.
- ◯ **Modified/partial/blended bedside report** where part of the handoff (SBAR Report) is done away from the patient and part is done at the bedside (Safety check and introduction). It is acceptable to complete part of the report at the nurses' station.
- ◯ **Full report at the nurses' station** (There is no need to include patient and/or family in the report/handoff process).
- ◯ Other (please specify)

* 36. What is the best name for conducting a bedside report where part of the handoff (SBAR Report) is done away from the patient at nurses' station and part of the handoff (Safety check and introduction) is done in the patient's room at the bedside? **What do you think this type of report should be called?**

- ◯ Hybrid bedside report
- ◯ Modified bedside report
- ◯ Blended bedside report
- ◯ Partial Bedside report
- ◯ Other (please specify)

37. In your opinion, what are the barriers/challenges with completing partial or full handoff/report at the bedside?

38. Is there anything else you would like to add to improve the change of shift report/handoff process?



Appendix M: *Executive Summary of Project Results to Nurse Executives*

EXECUTIVE SUMMARY

Prepared for:

SCVH Nurse Executives

Prepared by:

Nathan A. Barfield
UCLA DNP Student

SUMMARY

In response to the Joint Commission's 2006 National Patient Safety Goal aimed at improving communication and handoff in patient care, many healthcare organizations have adopted bedside shift reports. The Joint Commission issued Sentinel Event Alert #58, "Inadequate Hand-off Communication" (2017), highlighting the urgency for healthcare organizations to address this safety concern.

PROBLEM STATEMENT

Despite the benefits of bedside report, many healthcare organizations have encountered challenges with its implementation and sustainment due to barriers raised by both nurses and patients, including time constraints, privacy concerns, interruptions, and distractions during report.

SOLUTION

Modified bedside report where information is exchanged outside the patient's room (SBAR), and essential safety, Plan of care updates, and introductions occur at the bedside. This approach takes into consideration the reported barriers to bedside report, provides a space for nurses to communicate effectively without interruptions, and still includes patients in the handoff process, which promotes safety and satisfaction with care.

OPPORTUNITIES

Enhance nurse satisfaction, foster effective communication, and promote patient involvement in their care. Pre/Post Nurse Survey completed with significant results in nurse familiarity with modified bedside report, confidence in completing handoff, consistency using the process, conducting a focused assessment, and nurse preference for modified versus full bedside report.

FINANCIAL SUMMARY

A brief training was completed with nurses during huddles, meetings, and email. No additional cost was associated with training nurses. There were Minimal costs related to printing patient education brochures and posters offering an effective solution for organizations who are committed to SAFE PATIENT CARE!

Appendix N: *Potential Modified Bedside Report Policy for Expansion to Other Inpatient Units*

Patient Handoff Using Universal SBAR and Modified Bedside Report

Enterprise 0365

Date: 6/13/2025

To:

All Enterprise	X	Contractors Only	
Site Specific Workforce		Medical Staff Only	
Department Specific		Volunteers Only	

From: Chief Nurse Executive

SUBJECT: **Standardized Patient Handoff Using Universal SBAR and Modified Bedside Report**

SCOPE:

Location (includes hospital and all inpatient and outpatient locations and subacute facilities of the hospital, unless otherwise indicated)	
Enterprise Wide	X
Hospital A	
Hospital B	
Hospital C	

BACKGROUND: The Joint Commission, a leading authority in healthcare, implemented a National Patient Safety Goal in 2006 aimed at improving effective communication and ensuring safe patient handoffs. The handoff is the transfer and acceptance of patient care responsibility through communication between caregivers, a process crucial for maintaining the continuity and safety of patient care and reducing errors (Joint Commission, 2017). The Joint Commission created 8 Tips for High-quality Hand-offs:

1. Determine critical information that needs to be communicated. Cover everything required to care for patients in a timely and safe manner.
2. Standardize tools and methods used to communicate. These can include forms, templates, checklists, mnemonics, patient summaries, and action lists.
3. Don't rely solely on electronic or paper communications to hand off. Allow the time and opportunity to ask questions.
4. Combine information from multiple sources and convey it all at once, rather than communicating the information separately.
5. Ensure the receiver receives information about the illness assessment, patient summary, events leading up to the illness or admission, hospital course, plan of care, to-do list, allergies, code status, medication list, laboratory tests, and vital signs.
6. When conducting handoffs, do them face-to-face in a location free from non-emergency interruptions.
7. When conducting a hand-off, include all team members and, if appropriate, the patient and family. Discuss the plan of care, ask and answer questions.
8. Use electronic health records and other technologies to enhance hand-offs between sender and receivers (Joint Commission, 2017).

POLICY:

A. The SBAR (Situation, Background, Assessment, Recommendation) format shall be the standardized method used to communicate patient hand-offs between shifts, departments, relief staff, and providers. This process aligns with the Joint Commission's National Patient Safety Goal 02.05.01 and the 8 Tips for High-quality Hand-offs.
B. In addition to the standard SBAR format, modified bedside report will be utilized as part of the hand-off process in the inpatients units to ensure patient involvement in their care, enhance communication between healthcare providers and patients, and ensure a safety handoff is conducted at the bedside to promote safe, high-quality care, and effective communication.
C. Modified bedside handoff allows for nursing staff to complete the history and details about the patient's care outside the patient's room, and safety handoffs and updates are conducted with the patient/family inside their room.
D. Hand-off communication enables the transfer of pertinent information and provides an opportunity to ask and respond to questions. Patient hand-off is timely, accurate, complete, and unambiguous.
E. Interruptions and distractions during hand-offs are limited to minimize the possibility that information will fail to be conveyed or be forgotten.

PURPOSE: **To describe the process for communicating patient hand-off using the Universal SBAR method and modified bedside report.**

DEFINITIONS

SBAR

S—Situation (identifying information)

- This section contains the patient demographics and current situation. This includes the patient's diagnosis and current condition, including their current medical status, current medications, allergies, and recent lab values.

B-Background (background information relating to what is going on during the current patient encounter)

- Appropriate patient/population-specific information related to the pertinent history, medication, health and surgical histories, comorbidities, treatments, tests, and precautions.

A—Assessment (comprehensive assessment of the patient's condition by systems, including any recent changes in condition or treatment).

  - What is the patient's problem now?
  - Assessment of conditions or treatment
  - Any recent changes in condition/treatment
  - Last/current vital signs, pain level/medications, lines and drains, immediate concerns, and stability

R—Recommendation (Anticipated changes in condition or treatment)

- What to watch for in the next interval of care
- What does the patient need
- Anticipated change in condition or treatment
- Goals, plan, special needs, and potential problems

Modified Beside Report: The process will include two phases:

- The SBAR Communication may be completed outside the patient's room, where the reporting healthcare provider communicates patient details with the receiving healthcare provider.
- Safety hand-off and introductions will be conducted at the bedside in the patient's room to ensure patient involvement. The patient will have the opportunity to ask questions or clarify any concerns during this phase.

Receiving Healthcare Provider: The healthcare provider receiving/assuming care of the patient.

Reporting Healthcare Provider: The healthcare provider receiving/assuming care of the patient and will be transferring care to a receiving healthcare provider.

Assigned Healthcare Provider: The healthcare provider assigned to a patient or team of patients.

PROCEDURE

A. SBAR Handoff: At the time the patient care is handed off, the reporting healthcare provider who is transferring care of the patient will communicate about the patient's care using the SBAR format and Professional Exchange Summary in the electronic health record. This includes discussing information about the patient's care, such as their current condition, pertinent background and history, assessment, and treatments, as well as any recent or anticipated changes to be communicated to the receiving healthcare provider. Significant tasks that were or need to be completed, such as labs or tests, medication administration, and tasks including admission documentation, restraints, surgical or dialysis checklists, and any pending Chlorhexidine or Theraworx baths, should be addressed. This communication will preferably occur verbally and may be conducted outside or inside the patient's room, depending on the patient's preference and clinical condition. An opportunity to exchange and discuss pertinent information and needs should be provided to patients and visitors.

B. A safety handoff will occur at the bedside unless there are extenuating circumstances that are charted in the patient's healthcare record.

C. Safety handoff should include the following:
   a. Explain to the patient and/or representative that you will be completing a shift-to-shift transition of care safety handoff. Ensure that you clearly explain what you will be doing, invite the patient to participate, and obtain their consent.
   b. The reporting healthcare provider should introduce the receiving healthcare provider to the patient and guests.
   c. The receiving nurse will update the communication board with their name and any pertinent information.

d. The reporting healthcare provider will conduct a quick, focused assessment with the receiving provider, highlighting any pertinent information (Such as Skin issues, neurological changes, lines, drains, etc.).
e. All high-risk medication should be handed off, following the independent double check (See Policy 0100) for the list of high-risk medicines.
f. The receiving and reporting healthcare providers will sweep the room for any safety concerns (i.e., assessing physical safety, bed alarms, fall risks, and ensuring proper equipment, supplies, and isolation supplies, etc.).
g. The receiving and reporting healthcare provider will check the 4Ps, which may include checking the patients pain/comfort level, making sure the patient is in a safe, comfortable position, check to see the patient needs to use the restroom/incontinence, ensure the patient has high risk possessions including hearing aids, glasses, dentures, phones, and computers.
h. If the patient has an order for telemetry monitoring. Ensure that the patient is connected and evaluate the rhythm.
i. Ensure the patient's needs are being met while hospitalized and involve the patient in the plan of care by asking the following questions:
    i. Ask patient/visitors, “Were your previous goal(s) met?
    ii. Ask patient/visitors, “Do you have any worries or safety concerns you would like to share?”
    iii. Ask patient/visitors, “What are your goals for the next shift (12 hours)?”
    IVIV. Do you have any questions for me?
j. Documentation of patient hand-off communication is recorded in the EHR using the SBAR Report Given to Navigator.

APPROVAL PATH:

Department or Committee	Responsible Person	Date
Nursing Standards Committee		
Executive Nursing Council		
Chief Nursing Officer		
Medical Leadership Council		
Policy Review Team		
Health and Hospital Committee		

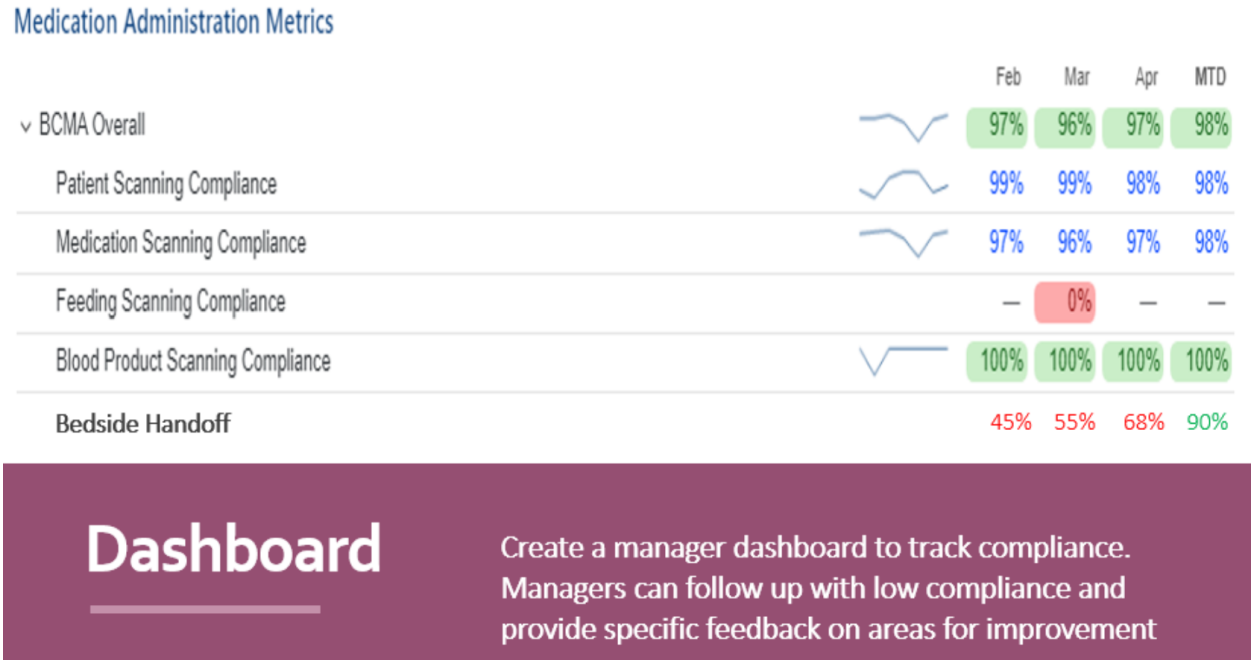
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Appendix O: *Using Barcode Scanning to Measure Compliance of Modified Bedside Reports*



Benefits of Project

Create a System for Measuring Bedside Report that Uses Technology
Enhance Compliance and Accountability
Streamline Workflows
Improve Data Accuracy and Consistency
Cost Effective Utilization of Existing Technology
Enhanced Patient Experience
Increased Transparency and Feedback
Quality and Compliance Metrics
Improved Culture of safety

Appendix P: *Using Barcode Scanning to Measure Compliance with Steps and Poster*

Goal 2: use Barcode Scanner to document handoff items

How I envision barcode scanning working and need help on feasibility. How can it work? What are challenges? How much time would it take?

Step 1	Log-in to Desktop
Step 2	Open HealthLink
Step 3	Scan Patient's ID bracelet to log into chart
Step 4	Scan SBAR Handoff Flowsheet (Barcode or QR code)
Step 5	Scan Item to handoff (Foley, IV, Bed alarm)
Step 6	Scan Completed, Not done, Patient off unit, N/A, etc.
Step 7	Scanned item documented in the corresponding Row

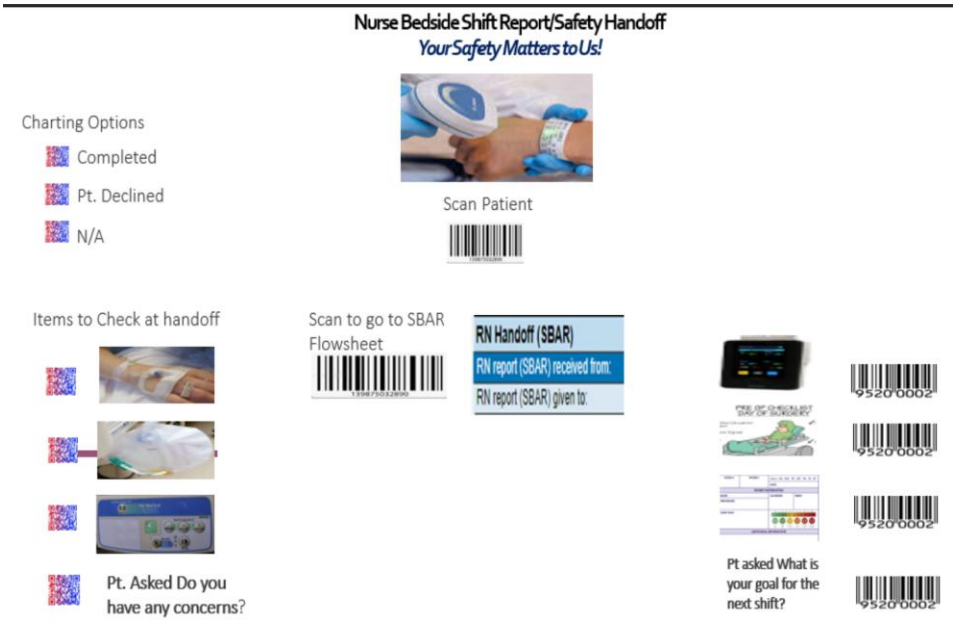


TABLE OF EVIDENCE

CITATION	PURPOSE	SAMPLE/SETTING	METHODS (Design, Interventions, Measures)	RESULTS	DISCUSSION, INTERPRETATION, LIMITATIONS
Elgin, K. W., & Poston, R. D. (2019). Optimizing registered nurse bedside shift reports. *Journal for Nurses in Professional Development*, *35*(2), E6–E14.	To examine the effect of simulation-based training for RNs to increase adherence to AHRQ-defined critical elements of RN bedside shift report	26-bed adult Med-Surg unit Located in the Southern U.S. Thirty-eight total RNs with a unit-wide range of experience, from new graduates to 25 years BSR occurs approximately fifty-two times in 24 hours. Recruited at staff meetings and daily team huddles, posted on the unit	Pre-experimental pretest/posttest. Single cohort. IRB obtained. Staff completed a demographic and self-efficacy survey. After the pre-survey, RNs completed 2-hour Simulation interventions that reviewed the AHRQ bedside shift report, participated with peer RNs in a simulated bedside shift report for two standardized patient cases, and a debriefing.	Adherence to AHRQ guidelines was compared using mean score pre-simulation and post-simulation using the Wilcoxon signed-rank test. Increase in RN adhered after simulation (Z=-4.230, p=.000) mean score after simulation 4.938 (SD=0.5578) compared to 3.167 (SD=0.9049) pre simulation (p=.000) Simulation methods have benefits and applicability to RN training.	The study provides an observation checklist that can be used to observe bedside reports, which is a valuable tool. A self-efficacy survey is a valuable tool. Used AHRQ guidelines for bedside shift reports. Limitations: Implementation was completed for one unit, and some participants resigned due to the aggressive protocol timeline.

Grimshaw, J., Hatch, D., Willard, M., & Abraham, S. (2020). A qualitative study of the change-of-shift report at the patients' bedside. *The Health Care Manager*, *39*(2), 66–76. https://doi.org/10.1097/hcm.0000000000000291	Identify nurses' perceptions in Med-Surg and ICU, regarding bedside reports at transition of care. The authors sought to understand the factors that influence the consistency and frequency of BSR.	Community hospital in Northern Indiana	Qualitative Study Wanted to understand the advantages and disadvantages of BSR. Personal interviews were conducted with seven medical, surgical, and ICU nurses. Digital recordings and handwritten notes were completed during the 1:1 interview to identify themes related to BSR.	**Theme One:** Six out of seven nurses indicated that BSR takes longer than completing the report at the nurses' station. Patient needs arise during the report, and patients can be needy. Families may ask questions that have already been discussed with the patient. Other delays: Some RNs conduct a quick assessment and may need to report to multiple RNs. **Theme Two:** Six out of seven RNs reported that BSR promotes continuity of care, patients are more involved in care, and introductions enhance the nurse-patient relationship. **Theme Three:** Six out of seven RNs reported they used a modified BSR. Most of the report took place outside the room, and then introductions followed. RNs cited that accessing the chart and confirming orders on the computer was easier and more efficient outside the room. **Theme Four:** Five out of seven RNs reported that BSR provides visualization of the patient. Check IV sites, pain, safety measures, and level of	BSR promotes patient-centered care. Patients feel involved in their care. Nurse leaders must allow their staff nurses to complete a modified BSR to maintain confidentiality and ensure their staff nurses' well-being. BSR allows for early visualization of the patient. Recommend: Divide the report into two sections for nurse convenience and patient satisfaction, including the main report outside of the patient's room and introductions/"Up manage" oncoming RNs. RNs indicated that they could save time by completing part of the report and RN station, and then using a modified BSR to

				consciousness with the outgoing RN. **Theme Five:** 5/7 RNs felt they could not say everything in BSR. Preferred report at the nurse's station where they can talk freely without breaking confidentiality if visitors/neighboring patients present/sensitive issues.	promote the nurse-patient relationship. The literature review encompassed articles published between 2006 and 2013.
Jimmerson, J., Wright, P., Cowan, P. A., King-Jones, T., Beverly, C. J., & Curran, G. (2020). Bedside shift report: Nurses' opinions based on their experiences. *Nursing Open*, *8*(3), 1393–1405. https://doi.org/10.1002/nop2.755	Examined the experiences/ opinions regarding BSR. Identified barriers and facilitators to BSR from clinical nurses and nursing supervisors, and examined common themes.	A 500-bed academic medical center in the southern United States. At least one clinical nurse from the 15 inpatient units was included. Supervisors were only included if they had at least one year of supervisor experience in the unit.	Phenomenological Qualitative Study using a purposeful sampling method to ensure participants had firsthand experience. N=22 Clinical RNs N=12 RN Supervisors The iPARIHS framework was used to design the interview guide. Interviews were conducted in a private room at the medical center and lasted between 30 and 60 minutes.	**Theme One:** Time constraints and clinical nurses' workflow must be considered. **Theme Two:** A modified approach is necessary. **Theme Three:** Process and specific critical content should be individualized to ensure it is helpful and meaningful for all patients involved. **Theme Four:** Specific critical content should be discussed inside the patient's room. **Theme Five**: Specific critical content that should be discussed outside the patient's room.	Conducting a modified BSR may reduce interruptions and delays.

Martini, A., & Resek, J. (2021). A practical guide to implementing bedside report in a critical care setting. *Critical Care Nursing Quarterly*, *44*(3), 324–333. https://doi.org/10.1097/cnq.0000000000000368	To examine the effects of blended bedside report, including completing part of the report outside of the room and a portion at the bedside	Large teaching hospital. The number of beds was not indicated. 22-bed Neurosurgical ICU The unit-based council chose six RNs to become bedside report champions.	A bedside report (BSR) is conducted in the patient's room. A blended report occurs when half of the report is conducted outside the room, and the other half is performed inside the room, identifying a lack of standard shift handoff. Importance of BSR. New standardized BSR. Created BSR checklist (handoff outside room, a patient safety check, and a room/environment assessment) Training for RNs included a mock report from the champion, debriefing (three weeks during shift), and two weeks of daily huddles. An anonymous presurvey was conducted to examine nurses' perceptions of BSR. Blind observations of RN shift handoffs and recorded the number of RNs who went into the patient's room and completed BSR. 30- and 90-day following implementation, staff participation and attitudes of staff were evaluated	Thirty days after implementation, the Unit secretary and respiratory therapist audited the shift change. Compliance increased from 34% to 80%. 30-day post-RN attitude anonymous survey: 80% strongly agreed, 20% agreed (5pt Likert) that blended BSR promotes patient safety. One-year post-implementation audits showed a 94% compliance rate. Other units in the same hospital adopted some portions. There was inconsistency, and the same results were not obtained.	The results are in one unit. The authors mention that other units using portions did not obtain the same results. Pre/post surveys were anonymous, not linked, and had no statistical analysis. A BSR checklist was provided, which outlined what was checked outside the room, the patient safety check, and the room environment. This may be useful for a project that will create a similar checklist. Supports the use/consideration of a modified report instead of a full BSR and the importance of transparent processes/instructions for BSR. Supports training Superusers to train bedside RNs during shifts.

McAllen, E., 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).	To examine whether implementing BSR improves patient safety (i.e., reduction in falls) and patient and nurse satisfaction.	532-bed acute care midwestern hospital, which is a Magnet-designated hospital. A team comprising nurse administrators, directors, staff nurses, and a patient representative was formed to conduct the literature review and provide recommendations for practice change.	An evidence-based practice change was implemented, incorporating bedside reports into standard nursing care. Fall rates, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), Press Ganey scores, and nurses' responses to a satisfaction survey were used to measure before/after implementation over four months. Gap analysis performed: BSR was not a practice; the report was typically done in the conference room, at the desk, or in the hallways. The Iowa Model of Evidence-Based Practice and Kotter's Eight-Stage Process for Major Change were used to guide implementation and sustain progress. The test of change in PDSA cycles was used to evaluate the practice change and make adjustments. BSR was timed.	Patient fall rates decreased by 24%. Nurse satisfaction improved with four of six nurse survey questions (67%). HCAHPS and Press Ganey improved patient satisfaction in two of the three units. The implementation of bedside reports had a positive impact on patient safety and satisfaction among both nurses and patients. Pre (46) and Post (48) BSR observations, no statistical significance between the mean report time. Nurses perceived that BSR took longer, but recognized the value of BSR.	The study was conducted in only three units of the same hospital. Excellent example of the Introduction-Situation-Background-Assessment-Recommendation-Questions (ISBARQ) report tool. An in-depth literature review that shows the positive impact of BSR on patient fall rates and patient and nurse satisfaction. The five articles in the literature review were from 2010 to 2013 and may be too old to apply to this project. Kotter's change theory and PDSA were utilized. Strong nursing survey tool. Nurses suggested improvement in

					communication and teamwork.

Scheidenhelm, S. & Reitz,O. (2017). Hardwiring Bedside Shift Report. JONA: The Journal of Nursing Administration, 47 (3), 147-153.	To increase patient satisfaction scores, use a change management process to gain buy-in with bedside reports. To improve nurse compliance with bedside reports.	149-bed community hospital in Illinois. Two units, a 46-bed medical/surgical unit, and a 12-bed obstetrics (OB) unit. The med-surg unit was selected because it represented the general population regarding age and sex. OB unit was selected because of higher patient satisfaction scores and higher compliance with bedside reports.	Quasi-experimental between-group Pre-implementation and post-implementation comparison of patient satisfaction scores from surveys Lewin's Theory of Planned Change was utilized to hardwire bedside reports. RNs trained in the simulation of bedside reports.	A change management strategy and standardization approach to bedside reports increased compliance with the report. Four months post-implementation, n=190 surveys for M/S unit and n=9 for OB Observations pre-implementation n=73 (12% complian	The Joint Commission recommends a standardized handoff between care providers. Bedside reports enable patients to communicate and input about their care, using a standardized approach. The organization initiated the bedside report in 2009 but has faced inconsistencies in frequency and quality of care. Nurse compliance with bedside reports increased when a change management strategy was implemented.

				ce rate), M/S n=59 OB (55% compliance with report). Three months post implementation, n=94 M/S (85% compliance rate), n=53 OB (84% compliance).	

CITATION	PURPOSE	SAMPLE/SETTING	METHODS (Design, Interventions, Measures)	RESULTS	DISCUSSION, INTERPRETATION, LIMITATIONS
Webster, K., Hlebichuk, J., Jensen, L., & Zastrow, R. (2024). Coasting through bedside report. *Journal of Nursing Care Quality*, *40*(1), 69–75. https://doi.org/10.1097/ncq.0000000000000802	To standardize items discussed during bedside handoff using the acronym COAST (Code Status-Oxygen-Access-Safety-Tubes/Drains)	A 938-bed medical center located in the midwestern United States. The setting was in a 24-bed medical respiratory intensive care unit.	A nine-month pilot followed by a 12-month sustainment period that introduced the organization's five most common overlooked handoff items. Utilized the revised Iowa Model of EBP. Education was completed at the staff meeting and emailed to all nursing staff. Visual signage was hung on the door of all patient rooms. Post-survey19/79 nurses took the survey. N=17, 89% found the COAST tool valuable.	Baseline data, comprising 30 audits, showed an average compliance rate of BSR at 5%. Increased to 58%-69%, with some drift back to previous practice during the sustainment period. Observed for "good catches" including "no CPR" wristbands, oxygen setting, outdated IV tubing/not labeled, outdated dressing, no suction setup in room, chest tube suction incorrect, etc. 16 good catches were observed during the pilot period and eight during the sustainment period. Standardizing communication and safety items using a blended BSR	Common concerns with BSR include patient interruptions, apprehensions about disclosing sensitive information, and lengthy reports. Patient concerns: lack of understanding medical jargon, repetitive information, privacy concerns, anxiety, information overload, inaccuracies,

					inconsistency in completing BSR. Change management and project initiatives require the engagement of clinical and frontline staff. Project champions who are peers can establish trust and reduce resistance to change. It is important to incorporate feedback from frontline nurses and shared governance.

CITATION	PURPOSE	SAMPLE/SETTING	METHODS (Design, Interventions, Measures)	RESULTS	DISCUSSION, INTERPRETATION, LIMITATIONS
Wollenhaup, C. A., Stevenson, E. L., Thompson, J., Gordon, H. A., & Nunn, G. (2017). Implementation of a modified bedside handoff for a postpartum unit. *JONA: The Journal of Nursing Administration*, *47*(6), 320–326. https://doi.org/10.1097/nna.0000000000000487	To test a hybrid report model, some of the reports were conducted privately outside the room between RNs, and some were done in the patient's room. The goal was to increase compliance with seven components of the standard report, which included: background, introduction, time and type of delivery, assessment of wounds, incision drains, IV	13-bed postpartum unit. 110-bed rural hospital 28 RNs N=50 patients who were in the first few days postpartum with viable infants. Two RN champions on days and two on nights	Uses SBAR report method. Process of the report: Review outside of room EMR, SBAR, and develop goals. The remainder of the report at the bedside Introduction Determine pt goals for shift, discharge goals, ask questions. Pre/post-implementation design measured the frequency of BSR compliance. Patient/staff satisfaction with BSR Lewin's Theory of Change was used. Patient satisfaction questionnaire Staff satisfaction questionnaire	Audits were completed by champions at baselines and for two months. Pre-completion compliance 26%, post=84%, P=<.001 in all seven components of BSR. Patient satisfaction survey on a seven-point Likert. Independent sample t-tests 28% increased. P<.001. Staff satisfaction survey (7-pt Likert). Increased by 40.34%. P<.001	Highlights the importance of the patient/family being allowed to ask questions. Used guidelines, checklist. Questionnaires were developed by the author from the literature review and were not a validated tool. Using champions and support may have contributed to nursing 40.3% engagement and increased compliance. The goal of 95% compliance was not achieved. The authors recommend continued observation and reinforcement, which will further help to increase compliance.

	sites, check order, allergies, tasks, labs, goal setting, and questions.				The goal was to increase staff satisfaction by 10%. The goals were exceeded by 40.3%. Convenience sampling is used in the authors' project, specifically in a small, rural hospital.

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