Bedside Nurse Shift Report: Standardizing the Approach at the Bedside

Tracie Heckman MSN, RN, CMSRN
Lehigh Valley Health Network, Tracie.Heckman@lvhn.org

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6B Medical Surgical Unit

Lehigh Valley Health Network, Allentown, Pennsylvania

Background:

The organization's care delivery model has been patient centered care. Bedside Nurse Shift Report is a sub project of redefining the culture of family presence throughout the organization. A 34-bed medical surgical unit embraced the concept of handoff communication performed at the bedside and became the pilot unit for this project. In addition to redefining the culture, quality issues in conjunction with an organization's commitment to employ best practice supported this pilot and standardization of the process throughout the network.

Evidence:

- Atwahl, P., Fields, W., & Wagnell, E. (2009). *Standardization of Change-of-Shift Report.* Journal of Nursing Care Quality (24), 2 p. 143-147.
  - Bedside nurse shift report provides crucial handoff communication between care givers at the change of shift.
  - Provides a standard way to deliver information. Promotes best practices, patient safety, quality, and employee satisfaction.
- Caruso (2007). *The Evolution of Nurse to Nurse Bedside Report on a Medical-Surgical Cardiology Unit.* MEDSURG Nursing (16) p.17-22.
  - Supports above findings for implementing a shift to shift bedside report.
  - Presents a clinically relevant opportunity for two nurses to visualize and communicate with the patient at the time of handoff.

Implementation:

- Standard "SBAR Report Card" for utilization by all RNs
- Education for all RNs regarding Bedside Nurse Shift Report and associated evidence to support best practice
- Patient education brochure that addresses the handoff process
- Staff were validated on their handoff report 6 months post implementation
- Support from the management team is essential
- Coaching, coaching, coaching…. Key to success
- Time study was completed prior to implementation and at 4 months to compare
- Staff were validated on their handoff report 6 months post implementation
- Updates both positive and areas of opportunity were sent to the staff weekly for the first 6 weeks

Post Implementation:

- Coaching continues to new staff
- Staff are held accountable to the new process
- Time study proved that handoff was more efficient at the bedside
- Management rounds with patients to ensure compliance
- Staff received survey again at 3 months and 1 year
- Standardized process rolled out to all medical surgical and step down units, as well as the emergency department

Measurements:

- Incidental Overtime Dollars
- Patient Satisfaction Scores
- Nurse Sensitive Quality Outcomes
- Staff Attitude Survey

Lessons Learned:

- Pilot unit should have utilized the report card prior to implementation
- Be consistent throughout the education process
- Validate throughout the year
- Management must be vigilant and present to ensure the process is completed correctly
- Coach, coach, coach prior to holding staff accountable

Staff Survey Results for Pilot Unit at One Year:

- *67% would be disappointed to return to prior method of handoff*
- *100% felt that the bedside report compared to the previous method of handoff was mostly or more than adequate*
- *84% felt mostly prepared after bedside report*
- *94% felt that they had identified at least once a potential safety hazard and a patient deterioration during report*