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Bedside Reporting

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Bedside Reporting

by

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Abstract

Bedside reporting can directly correlate with preventing errors in the healthcare setting. The three main errors that occur are falls, medication errors, and sentinel events. These errors have a vast number of different outcomes, even resulting in death in some cases. Despite The Joint Commission directly stating that bedside reporting is best practice, this is not always what is conducted in many hospital organizations. Literature has suggested the problem that exists with implementation is the longevity of the implementation from staff. Identifying a feasible and conducive way to implement bedside reporting that is both favorable for the patient and staff directly combats these errors. The purpose of this MSN project was to refine the way bedside shift reporting is being completed, for the better of the patients and staff. The purpose is to give patients the autonomy to decide whether they would like to be included in the bedside report. The patient would be asked during each shift, ensuring that they are still given the option. It would be important to educate the patient that safety checks would still be completed, the report could just be given without involving the patient. The objectives of the MSN project were to decrease falls, medication errors, and sentinel events; all nurses on the unit will be using the standardized method in their practice; patient satisfaction will increase. Due to the limitations of this MSN project, such as a baseline assessment of the number of falls, medication errors, sentinel events, nurse compliance with bedside reporting, and patient satisfaction percentages, further research is needed to strengthen the research and results of the project.

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CHAPTER I

Introduction

Bedside reporting is known best by nurses as a way of completing handoff on a patient at the end of the shift that directly involves the patient in their plan of care as well as looking at anything pertinent to the patient. Bedside reporting, in theory, is an excellent way to complete shift reports for nurses. The reality of this is it is not always done as intended. It is also something not taught, or taught in a limited capacity, in nursing school as the focus remains on the actual development of becoming a safe, competent nurse. There are also many advantages and limitations that come with completing shift reports at the bedside. Completing bedside reporting allows nurses to actually visualize the patient's current condition being discussed and view anything pertinent such as wounds, incisions, and drips.

Significance

The sole intention of participating in bedside reporting is to ensure and promote patient safety. By directly involving the patient in this report, it allows the patient and family to actively participate in developing the plan of care. Laws and Amato (2010) state "the nurse-patient interaction during bedside report provides benefits to both patients and nurses. A bedside report reassures the patient that the nursing staff works as a team and that everyone knows the plan of care." Bedside reporting also has the ability for the patient to develop a greater understanding of what is going on and provides the opportunity for patient education.

Problem

The problem that arises with bedside reporting is it is not being done correctly or it is not being done at all. Often, the patient is asleep and not involved in the report, especially during the morning report. If this is the case, the patient is unaware bedside reporting took place and inaccurately responds to survey questions when posed to the patient by the administration. Another problem that can arise is the nurses open the patient's door and just begin talking, not getting the patient involved. This ultimately confuses the patient and does not involve the patient in the care process. The greatest concern occurring with bedside reporting is it is not being done at all. Many nurses who are told to do bedside reporting stand at the patient's closed door and provide the report to the oncoming nurse. This does not allow the oncoming nurse to visualize the patient and is dangerous practice according to research. This problem is an extremely important matter as bedside reporting can aid in preventing sentinel events. If there was a change in the patient's condition, there are now at least two nurses looking at the patient and are able to act much quicker than what would happen if the nurse would finish getting the report and then go into the room to medicate the patient later in the shift. Time can be of the utmost importance with patient events and every minute counts.

Purpose

The purpose of this MSN project is to refine the way bedside shift reporting is being completed, for the better of staff and patients. Ideally, the goal of this project is for 100% of nurses to conduct bedside reporting at the selected facility. Education for both staff and patients will need to be completed in order to reach this goal. Patient safety and

outcomes are expected to improve, with fewer sentinel events, through the implementation of this project.

Not only does bedside shift reporting involve the patient, but there are also many benefits to nurses. Malfait et al. (2016) write “the interaction with the patient and the room during the shift report enables nurses to prioritize their shift work better. This enhanced prioritization improves the nurse’s accountability, medication reconciliation, and enables more effective communication with physicians after the handover.”

Definition of Terms

Bedside reporting is the act of a nurse or certified nursing assistant (CNA) reporting the patient’s bedside, including the patient and family members in the plan of care. In this specific project, bedside reporting will be the act of the nurse leaving and the nurse coming onto shift entering the patient’s room, and going through the entire report of the patient while allowing questions and input from the patient and the family.

Summary

There is an obvious need for improvement in the process that comes along with bedside reporting. When it is completed correctly, bedside reporting is a vital part of patient safety. Bridging the gap between what is actually done and what should be done is an issue that is constantly arising. The need for education with both staff and patients is the obvious need at hand. Much work and research will need to be completed in order to make this study a lasting, impactful mission.

CHAPTER II

Literature Review

Introduction

Bedside reporting is something many researchers have explored and attempted to correct, however, regardless of what ideas have come to be there seems to still be an obvious gap within organizations. This MSN project is aimed at correcting the obvious gap that still remains, despite all of the research that has been done and is available. The gap that has been present in bedside reporting is the lack of performance of it, as well as not utilizing the tools that have been provided by organizations for the nursing staff to use. A literature review was conducted to gain ideas and thoughts from others that have already conducted research on the topic at hand. Various sources used were Ovid, ProQuest, and Elsevier. Many different aspects of nursing were explored such as intensive care units, medical-surgical units, long-term care facilities, and perioperative services.

Literature Review

Bedside reporting was not always completed in the 500-bed Midwestern teaching hospital spoken about in this article. Olson-Sitki et al. (2013) note that previous to the implementation of bedside reporting, nurses would listen to a recording of the previous nurse, leaving no option for questions or actual introduction to the patient. Once the facility noticed this was an obvious problem, the facility implemented a 3-step model including unfreezing, movement, and refreezing. Once the education was complete, each nurse was given a bedside report checklist of what to ensure was handed off during the process. It was implemented as soon as the orientation process began for nurses to ensure

the nurses knew what the expectations were (Olson-Sitki et al., 2013). The problems that rose during this were during the refreezing phase of the implementation and had since dissolved them. This means that whenever bedside reporting was initially implemented, it was working, however, it relapsed for a period of time. Once this was realized, it was corrected and actually worked. To ensure the success of this program, nurse managers conducted check-ins with patients and staff and reported back to house supervisors on the results (Olson-Sitki et al., 2013). Concluding their article, Olson-Sitki et al. (2013) realized there was still the gap of unlicensed assistive personnel (UAP) that needed to be closed to prevent any reversion of the great strides they had made.

Bedside reporting can look much different in long-term care facilities but probably is not completed much at all. The article by Rogers et al. (2017) attempts to bridge this gap with intensive care unit (ICU) patients that have met the criteria to transition over to a long-term acute care hospital (LTAC). Using a computer-based survey, Rogers et al. (2017) questioned staff on bedside reports and from there created a standardized tool to be used for each shift report. Rogers et al. (2017) also placed an extra emphasis on the use of computers during bedside reports. Rogers et al. (2017) received much pushback during the beginning phases of implementation because of the length of stay most of the patients had. Rogers et al. (2017) used the report percentages on falls and medication errors to combat this. While there is still work needed, new hires and new nurse graduates have come to appreciate the work and the tool implemented in this facility (Rogers et al., 2017).

Sadule-Rios et al. (2017) previously noted nursing reports would be completed somewhere other than at the patient's bedside such as at the nurses' station or in a

medication room, often leading to negative impacts on patient safety. Sadule-Rios et al. (2017) include a case study of a nurse floated from an intensive care unit to a medical-surgical unit. In the case study, the nurse providing the report and going off duty was hesitant to give a bedside report to the oncoming nurse assuming care, even after the oncoming nurse requested a bedside report because the nurse going off duty was ready to leave work (Sadule-Rios et al., 2017). Despite this, a bedside report was conducted and it was then noticed one of the patients was in respiratory distress (Sadule-Rios et al., 2017). The fast recognition of this during the bedside report could have saved this patient's life. This case study was able to show the obvious gap and inconsistencies that exist between what should be done for bedside reporting and what is typically done. Sadule-Rios et al. (2017) promote the collaboration of multidisciplinary teams as well as collaboration with the patient, family, and staff within the article. While Sadule-Rios et al. (2017) still note there is a gap, the authors also note with the implementation of bedside reports there are fewer medication errors and greater communication among everyone involved.

Bigani and Correia (2018) conducted a study in a freestanding children's hospital in Southern California on the perceptions of bedside reporting from both the perspective of the staff and patient/family members. The hospital already had the expectation in place that bedside shift reports should be happening with every shift, originally rolling out the education in 2012 for the staff. An interview was completed with the patients and families that participated in the study, asking multiple questions about thoughts on the process of bedside shift reports (Bigani & Correia, 2018). Many of the points presented by the nurses as to why bedside reporting had so many barriers included that it was time-consuming, families did not want to be bothered, and the fact that so much information is

already being thrown at the family, and this was just additional information the family had to absorb (Bigani & Correia, 2018). Many of the families reported the reason they did not understand bedside reporting was from personal fatigue related to the current healthcare status of the family. Bigani and Correia (2018) noted an obvious need for further education of both staff and family, despite the success seen with the implementation.

Walsh et al. (2018) take a different perspective on bedside reporting, evaluating the nurse's perspective of how it is done, its effectiveness of it, and the accountability it presents. Walsh et al. (2018) gathered a group of nurses that worked at a specific hospital and gave the nurses tests regarding the accountability and structural empowerment of the bedside shift educational program developed within the organization. Walsh et al. (2018) presented a new tool to the nurses to aid in bedside reports including pertinent information that nurse managers decided to include. Once this occurred, the system went hospital-wide and all staff was educated on it, with a 1-month follow-up at a skills competency day. During this time, nurse managers were responsible for watching the bedside report occurring and accepting suggestions and changes throughout the process (Walsh et al., 2018). Walsh et al. (2018) include that there should be consistent reinforcement and an annual competency completed in order to effectively integrate this within a facility.

Like many other places, Jimmerson et al. (2021) noted the implementation of bedside reports is not the issue, it is the post-implementation adoption and acceptance. Jimmerson et al. (2021) explain while many studies have been conducted regarding the implementation of bedside reporting, it has yet to be found of a "perfect" way to

implement and complete it successfully. Jimmerson et al. (2021) aim to find what information is appropriate content for bedside reporting and the expectations that should be upheld in the hand-off process. In the study, Jimmerson et al. (2021) included a nurse from each unit at the hospital, ensuring a variety of opinions. Many of the nurses noted time constraints as one of the biggest issues and suggested a modified approach to bedside reporting is the answer (Jimmerson et al., 2021). Many of the nurses worried that specific content given could be perceived as something entirely different by the patient, ultimately setting the nurse up for failure. Ultimately, Jimmerson et al. (2021) presented the idea that the most success can come from a modified approach to bedside reports, meaning a portion of the hand-off occurs both in and out of the patient's room.

One of the most common transfers within a hospital occurs from the post-anesthesia care unit (PACU) to a unit such as a medical-surgical unit once the patient is medically stable to transfer. Popik et al. (2019) noted the most common way for those units to communicate reports is by telephone, meaning PACU nurses would have to step away from the bedside to give reports and the medical-surgical nurses would also have to step away from patients to receive the report. The main goal presented is team building and communication of caregivers in the post-operative phase. The new method implemented was for the PACU nurse to bring the patient to the medical-surgical unit and give the report to the new nurse directly at the bedside, promoting patient safety. This simple change was fully integrated into workflow practice from PACU to medical-surgical nurses, enhancing professional relationships throughout (Popik et al., 2019).

Dorvil (2018) notes implementing bedside reports is not the issue, it is sustaining it, especially with nurses that have been in the practice for quite some time and do not

conduct bedside reporting. Once someone is set in personal ways, it is quite difficult to implement change. Dorvil (2018) attempts to explain ways that can lead to the practice of sustainability. Many of the complaints of patients included not being able to understand what the nurses were saying, inconsistency in how the report was being done, and over time the redundancy of hearing the same things over and over again (Dorvil, 2018). While nurses note greater accountability and accuracy, nurses also note it takes much longer to report due to interruptions by patients and family members. The nurses also fear giving information to the oncoming shift that has not been disclosed to the patients at the time of report (Dorvil, 2018). While implementing the standard of bedside reports will take much time, the hardest part will be the continuous need for reinforcement of practice to be done by the nurse managers and assistant managers (Dorvil, 2018).

Pierce and Dietz (2013) note The Joint Commission has noted the root cause of sentinel events is ineffective communication that occurs from shift to shift. The main idea proposed to help combat this was to move the handoff from the nurse's station to the bedside using the electronic medical record. Pierce and Dietz (2013) obtained volunteers from each unit to become competent in the art of perfecting bedside reporting. Once the volunteers' units were prepared, the volunteers began implementing education for the patients and utilizing the various tools to see how the patients liked the information (Pierce & Dietz, 2013). Once staff accepted this change into personal practice and education was complete, patient satisfaction greatly increased. While Pierce and Dietz (2013) do not say exactly how the bedside report standards were created, the authors do mention every nurse manager rounded on patients discussing bedside reporting and every patient was pleased.

In an emergency department (ED) trauma center in the Midwestern, Campbell and Dontje (2019) implemented a practice quality improvement project to help prevent the high-risk period for medical errors, known as handoff. Like many other EDs worldwide, this particular hospital's ER was also excluded from the push to implement bedside reporting. Because this occurred, the emphasis in this research was this ED specifically (Campbell & Dontje, 2019). The goal was to incorporate a standardized SBAR worksheet that the ED nurses needed to utilize. In such a high acuity setting, it is essential nothing be missed during the handoff process, as it could lead to the loss of life. Many nurses reported the worksheet was easy to use and simple to implement into the handoff process. The concern that remains is the fact that it might not be sustainable and many nurses resisted change in current practice (Campbell & Dontje, 2019).

Summary

Despite all of the research conducted regarding bedside reporting, there is still a very obvious need for changes and improvements. Through many different healthcare areas, including ICU, perioperative, emergency services, and medical-surgical units, one constant was noted. The constant is the need for something different to be done with bedside reporting that is feasible and sustainable. By having sustainability, nurses can ensure patient safety and help prevent or decrease the length of sentinel events from occurring or the length of time they have occurred for. This MSN project is aimed at creating a tangible way of implementing sustainable bedside reporting. Conducting a literature review has shown various ways bedside reporting can be done, while also showing what should and can be changed in order to make it successful.

CHAPTER III

Needs Assessment

As previously stated, there is an obvious need for sustainable changes in bedside reporting. Bedside reporting implementation is not the issue, the issue lies in the lack of sustainability within it. However, bedside reporting is not something that can be easily tackled alone. A team will need to be in place with the same goal in mind in order for a sustainable implementation to occur. This team will have many moving parts in order for the implementation to work and change as deemed necessary from observation within the specified unit.

Target Population and Setting

There are two populations directly involved in bedside reporting. These two populations are all patients and nurses. The focus for this MSN project will be all patients and nurses within the specific hospital unit being targeted. The hospital being used is a local southeastern trauma level one hospital. The values this hospital exemplifies are consistent with that of bedside reporting. The organization is currently aiming to implement bedside reporting, but does not have a specific direction for implementation other than knowing it should be done. With the help of this organization, the implementation of this MSN project will only aid in the process of bedside report implementation. Within this organization, there are multiple ICU units in this hospital as well as several step-down units. By using the two specific populations of patients and nurses alone, an implementation might not be as smooth as it should be due to the large volume. The initial implementation will be for all patients and all nurses specific to one unit. This unit is a critical care step-down unit. This unit cares for very sick patients, and

many times, events are missed because of the lack of implementation of bedside reporting. Because of these events, this unit will be ideal, to begin with, to implement this MSN project's version of bedside reporting.

Sponsors and Stakeholders

The partnership most beneficial to implementing this MSN project would be the unit manager and assistant managers. These persons are identified as the project sponsors as well as stakeholders. The manager and assistant managers of this specific unit would be able to provide current bedside reporting statistical data from the organization. Based on these numbers, the MSN project will be able to identify barriers and gaps to take into consideration before implementation occurs. The main stakeholders that would need to be interested in the implementation of this specific type of bedside reporting would be the nurses on the unit. Since this unit is not currently at 100% implementation of bedside reporting, it is obvious there are some nurses who have concerns with the current process. By speaking with these nurses, this MSN project can have more people's input and seek to ensure the process meets the needs of all to gain support. Eventually, once this unit is in agreement with the idea, it would need to follow the chain of command to attempt to get the project implemented in the entire facility. The next person that would be considered to be a stakeholder would be the Chief Nursing Officer (CNO) of the organization. This person would need to be considered as the main decision-making body for changes put into practice within the organization for nurses.

Desired Outcomes

While bedside reporting is already being executed within this specific organization, it is still not being done as it should be. The desired outcome is 100%

reporting to occur at the patient's bedside. The impact expected to follow this change would be decreased medication errors, decreased falls, decreased sentinel events, and increased patient satisfaction. Ideally, implementation would decrease medication errors, falls, and sentinel events by 40-50% and increase patient satisfaction by 15-20%. The benefits of these changes are obvious. Implementing bedside reporting keeps the nurse leaving held to a higher standard to ensure all patients have the correct medications being administered, intravenous (IV) access lines are working, and alarms are properly on. By having nurses held to a higher standard, the oncoming nurse is able to start patient care much quicker than having to go back to correct mistakes that occurred during the previous shift. Doing bedside reports allows the nurse to stop right then and there and make the necessary changes for the patient's safety.

Outcomes are something that will need to be measured based on the changes occurring. The outcome needed with this MSN project would be 100% of reports being completed at the patient's bedside. Prior to the education, each nurse will be randomly audited on whether they do bedside reporting or not. If they do, it will need to be audited whether it is being implemented correctly or not by selected managers for the units. Once the random audits were completed, education specifically on the correct way to conduct bedside reporting will be completed and implementation will occur. One month after the implementation has occurred, the same nurses will be randomly audited by selected managers for the units. After completion of these audits, nurses that were not compliant will directly be spoken with and re-educated on what the proper completion is. Additional follow-up evaluations will be needed to ensure compliance remains at 100%. The nurses will also be given the option to provide any feedback or suggestions for change. Another

outcome that will need to be observed is with the patients. Patient satisfaction scores will need to be addressed prior to the implementation of this bedside reporting and then again one month after the implementation.

SWOT Analysis

The SWOT technique is shown in Figure 1. The purpose of this is to identify strengths, weaknesses, opportunities, and threats related to the project.

Figure 1

SWOT Analysis

Strengths	Weaknesses
-Accessible resources * Hospital administration * Hospital data * Staff **-Advantages** * Bedside reporting already in place * Already know staff and administration * Cost-effective method	**-Areas needing improvement** * Education needed for implementation * Staff already set in personal ways * No current standard for bedside reporting **-Available resources to strengthen these areas** * Education department * Management of unit * Data proving success once implemented
Opportunities	**Threats**
-Current social, economic, regulatory, or policy changes providing opportunities for growth * The Joint Commission * Organization already pushing for bedside report * Sentinel events **-Potential opportunities** * Cost-effective method * Management * No current standard for bedside reporting	**-Current obstacles** * Lack of data on the success of the study * Staff already set in personal ways * Longevity of success of implementation

There are many factors that will play a major role in this MSN project. Since this is a new project, there are also many factors playing against it. The strength of this

project is the Project Leader is familiar with the hospital administration to the project would be presented. This means hospital administration already has a good judgment of character for how the Project Leader likes to work and play things out. This gives the Project Leader an advantage over someone who would be blindly presenting to the leaders. Because of the fact that the Project Leader is close with the hospital administration, the Project Leader would also be able to easily have access to current hospital data for bedside reporting, medication errors, sentinel events, and falls. Another resource the Project Leader has is knowing many of the staff that would be participating. Another advantage that plays in favor of the project would be that this organization is already implementing bedside reporting, so education on that itself would not have to be as detailed. The education rolling forward would be geared toward a more specific approach to bedside reporting. Another huge advantage is that it is extremely cost-effective. It would cost very little, as supplies for the signs outside of patients' rooms are all that would be needed. The most expensive piece of this would be the time needed to provide education.

Like many new things, the project is bound to have some weaknesses. A weakness present is that the organization has pushed the initiative of giving bedside reports without giving a specific way to carry them out. Many of the staff took it as an "okay, what now?" experience. One of the greatest weaknesses expected to arise is what was common with many of the literature reviews: staff is being resistant to change. A small, but very manageable weakness is the education set forth for this project will be weak at first. Based on the knowledge the staff has of bedside reporting, the education can be adapted. There are many resources available to strengthen these areas of weakness

such as the education department. This department would have the best ideas of how to roll out material such as this. Another source that would be available would be the managers and assistant managers on the unit. The unit managers and assistant managers would be a huge resource in ensuring that once the project is placed into effect, it would actually be done. If there are nurses still questioning whether this project is actually worth implementing, the anticipated data proving success once it has been implemented would be the biggest factor.

Opportunities arise with most, if not all projects. A huge organization that would aid in the implementation of this project would be The Joint Commission. The Joint Commission has already provided seven recommendations to improve hand-off communication including "standardized training on how to conduct a successful hand-off" (2017). This brings up an additional point of sentinel events being the main rationale for the development of this project. Sentinel events are the main reason The Joint Commission has presented the seven current recommendations. Using these recommendations in the education provided to staff will be a key opportunity used. A final opportunity for growth is the organization is already implementing bedside reporting. This project aims to aid that process by providing a standardized way of implementing bedside reporting. By using the strengths and weaknesses presented, opportunities for growth and further education have risen. These include the project being a cost-effective method for making this happen and management is a key role in sustaining implementation. A huge disadvantage turned into an opportunity is that the organization currently does not have a standard for bedside reporting. Knowing the

strengths and weaknesses present for the organization and turning each into an opportunity for growth is the best way to ensure success moving forward.

Since this is a new project, there will be several threats to its success. As previously mentioned, there is a lack of data that will be able to be presented. With little data, there could be people reserved to buy into the project. The unit this would begin on is also a unit where many of the nurses have been there for several years. Because of this, there can be the threat the nurses are already comfortable with methods and processes and hesitant to change their current practice.

Resources

Resources are necessary to ensure the success of a project. For this project, the number of resources needed is very minimal. In the initial phase of education, a classroom or conference room would be needed to actually teach the material and a copier and paper to provide each participant with handouts of the educational materials. Once the education had been completed, a copier, paper, and laminator would be needed to create the paperwork to be outside of each patient's room. After this has been completed, the Project Leader would need the assistant managers to be a resource in auditing the performance of bedside reporting. The Project Leader would also need to use the assistant managers as a resource for the pre-and post-data collection or medication errors, falls, and sentinel events. The only true cost would be the paper needed to create the handouts and paperwork and the cost of the participant's time for the education and aid in implementation.

Team Members

Fortunately for this project, a small team is all that would be needed. Each unit it would be implemented on would have the same team. The Project Leader would remain the team leader, regardless of the unit in, which it would be taking place. Other key team members include the assistant managers and managers in each unit. The assistant managers would be key team members in providing data needed in order to prove the success of the project. They would also be the ones auditing the staff as the report is occurring. The assistant managers have knowledge of the education, as well as the organization's standards. The manager would also play a key role in the implementation. The manager would be the person in charge of assisting the Project Leader in making decisions about when each part of the project should be implemented. The manager would also help make adjustments to the process as necessary from the feedback provided. At this organization, the managers are in control of the unit budget, meaning any funds needed for the project would come directly from the managers.

Cost-Benefit Analysis

The cost-benefit analysis is presented in Table 1. All prices listed were found at a local office supply store.

Table 1

Cost-Benefit Analysis

Supplies	Costs
Box of copy & print plain paper	$50
3 packs of red paper	$70
3 packs of green paper	$70

Supplies	Costs
2 packs of black printer ink	$100
Thermal laminator	$36
Laminating pouches	$28

The cost-benefit analysis presented is extremely hard to adequately measure. The costs seem very minimal, especially when each unit will pay for expenses individually. There may also be units able to provide some of the equipment, such as a laminator, to further reduce costs. Each item listed is a rough estimate of what would be needed for each unit. The difficult part of this analysis would be that the benefits which cannot be monetarily measured. Decreased medication errors, falls, and sentinel events are things a monetary value cannot be placed on. It would be extremely difficult to place a monetary value on a life lost. Despite the small cost of the materials, the amount of safety that will be provided is immeasurably valuable.

Conclusion

With the conduction of the needs assessment, there were many needs and benefits that arose from the project. In order to promote success, the project will be implemented one unit at a time. Sponsors and stakeholders would mainly be the staff of the units, including nurses, assistant managers, and managers. The desired outcomes from bedside reporting are to improve patient safety and reduce sentinel events. Ideally, with the implementation of the project, medication errors, sentinel events, and falls are expected to decrease by 40-50% and patient satisfaction would increase by 15-20%. The SWOT analysis identified many nurses will be hesitant to change for the project because of the

fact many of them have worked on the unit for a number of years and without data proving a success, it could be questionable. Resources needed are minimal, compared to the benefits it could result. Overall, the project can be done with little money spent and could ultimately save the hospital millions of dollars in decreasing easily preventable events.

CHAPTER IV

Project Design

Once all of the research has been completed, it is also important to determine a way to implement the good and how to maintain it in order to prevent the bad. With bedside reporting, the dilemma is not how to go about it, the issue is how it can be maintained. Bedside reporting itself is a simple procedure to go about, but like the literature review represented, most organizations find that it is difficult to maintain compliance. The MSN project is designed to create a feasible way to maintain this idea that is conducive for both the patients and staff. Like any new project, an assessment of this project will need to be completed quite frequently in order to ensure best practice is being maintained and necessary changes will be completed. Great deals of education will need to be completed and maintained for both patients and staff.

This MSN project explores the idea of bedside reporting and a standardized way to go about it being performed. It will include education for both the nurses and patients. Nurses will be provided the education on how to properly conduct bedside reporting. The patients will be provided with education on what bedside reporting is and be given the opportunity to select whether they would want to be involved in it or not. This question would be something that would be asked on admission and once a shift. This is something that could be indicated by placing the patient's preference on a sign outside of the patient's door. The sign could have a simple laminated circle, green to indicate involvement is preferred, and red to indicate involvement is not desired. This sign could easily be flipped based on the patient's preferences. The nurses would enter the patient's room, introduce themselves, change the whiteboard and ensure alarms are on if

applicable; however, the door could be shut after that is completed for the report if the patient decides to not be involved in the reporting process. A potential problem that could arise with this system is a patient making the choice of who is not alert and oriented. In this case, it would be recommended for the nurses to implement the standardized bedside reporting method with patient involvement.

Goals and Objectives

The goals of this MSN project are quite simple. The most important goal of this project is patient safety. Implementing a standardized method for bedside reporting is anticipated to decrease medication errors, falls, and sentinel events. The objective to get to the goal of decreasing medication errors falls, and sentinel events are that with the implementation of the standardized method, within 1 month these errors will decrease by 40-50%. Another goal is to have 100% of the nurses on the unit using the standardized method within 1 month of implementation. Because of this implementation, patient satisfaction is also expected to increase by 15-20% within the first month.

The objective of the project is to change the process of bedside reporting to be conducive both for nurses and patients. Giving patients the opportunity to choose to be part of bedside reporting or not creates an environment favorable for individualized patient care.

Plan and Material Development

Project development has been split into multiple parts. First, the project leader identified the problem, which is the lack of a standardized method to complete bedside reporting at the facility, and created an objective to improve the problem at hand. After identifying the problem and establishing an objective, the literature was reviewed on

bedside reporting itself and the common strengths and weaknesses of the process. The information gained during the review of the literature was then used to develop educational materials and a standardized tool for the staff and patients. The Project Leader designed a PowerPoint presentation that will be presented to staff on the unit in which the standardized method will be utilized. The Project Leader also created a prototype of the laminated circle that will be placed outside of each individual patient's room.

Once all of the material has been developed, the Project Leader will present the idea to stakeholders. The stakeholders will be given the opportunity to present any strengths of the project, ask questions, and voice concerns or changes needed prior to the education beginning and being implemented. Once feedback is received, the Project Leader will analyze and make the necessary changes. After changes have been made, the Project Leader will then provide education to the assistant nurse managers on the unit, as well as the nurses. The assistant nurse managers will provide the education whenever the Project Leader is unable to do so. Education of all the nurses on the unit will take approximately a week and a half, giving extra days to account for illnesses and vacations. A roster will be signed by the nurse stating that they have received the education.

Once all of the nurses on the unit have been properly educated, implementation will take place. The signs will be placed outside of the patient's rooms and bedside reporting will begin. At the conclusion of 1, 2, 3, and 4 weeks, the assistant nurse managers or charge nurses of the unit will conduct audits to ensure compliance with the standardized method. If a nurse is found to not be compliant, they will be provided education, and if they continue to be non-compliant, disciplinary action will be taken by

the assistant nurse managers and managers of the units. At 1 month of implementation, the statistics will be measured for falls, medication errors, and sentinel events, and compared prior to the standardized tool being set into place. After a month of implementation and after numbers have been developed, the nurses and patients will be provided a questionnaire on the standardized method, as well as asking for ways that it works and ways that it could be improved. Once these have been reviewed, changes will take approximately a week to complete. These changes will again be implemented on the same unit for a month and the same method will be completed. After this month, the standardized method will be continued to additional units.

Timeline

The timeline for this project is subject to change based on feedback provided with each implementation. The timeline presented is an ideal timeline to go by. The Project Leader will take approximately 1 month to complete the necessary research and literature review to adequately be able to educate and disseminate the idea they are presenting. Once the project has been approved for facility implementation, the Project Leader will begin to educate on the project and how to implement it. It will take approximately a week to educate all of the assistant nurse managers on the standardized tool and how to educate staff when the Project Leader is unable to do so. After the assistant nurse managers are adequately educated, 2 weeks will be allotted to educate the entire staff on the unit of the standardized tool, allowing time for illnesses and vacations that may arise during this time. After this is complete, assistant nurse managers and charge nurses will begin auditing at 1, 2, 3, and 4-week increments. After 1 month of implementation of the standardized tool, statistics will be pulled by the assistant nurse managers of the

medication errors, falls, and sentinel events. The nurses and patients will be given 1 week to complete the questionnaire regarding the standardized tool. One week will be needed to go through all of the questionnaires and make the changes needed. One more month of observation and auditing will be completed in the specific unit before implementing the project hospital-wide. This timeline will take approximately 5 months to fully implement the project.

Budget

For this MSN project, the budget is planned to be low. The Project Leader estimates a $400 budget would be sufficient for development and implementation. This is a small cost compared to what could be a cost of a negligent error not found during bedside reporting. The supplies that will be direct costs would be approximately 1 hour of time for education, copy and plain print paper, three packs of red paper, three packs of green paper, two packs of black printer ink, a thermal laminator, and laminating pouches. Since the education can be completed in an hour, it would be feasible for the assistant nurse managers and the Project Leader to complete the education during the staff's working shift, avoiding the need for staff to come in on their day off.

All of the physical materials could be purchased at a local office supply store. A box of copy and print paper can be purchased at a local office supply store for $50. Three packs of red paper can be purchased at a local office supply store for $70. Three packs of green paper can be purchased at a local office supply store for $70. Two packs of black printer ink can be purchased at a local office supply store for $100. A thermal laminator can be purchased at a local office supply store for $36. Laminating pouches can be purchased at a local office supply store for $28. Purchasing all of these items will allow

for the educational material to be created for each of the staff members, while also having extra materials on the unit to fall back on for additional education. Each pack of colored paper would come with approximately 100 sheets of paper, meaning there would be 300 prototype laminated circles able to be created. On a 40-bed unit, this would allow for extra material and extra prototypes to be around in case one was to be misplaced or damaged in any way.

Evaluation Plan

With a new project such as that of this MSN project, there will need to be a lot of evaluating and assessing for success and ways of improvement. There will need to be data collection done both by evaluation of the bedside reporting, as well as by the surveys of the nurses and the patients. Evaluation of improvement in the standardization of bedside reporting will be measured by statistical data on falls, medication errors, and sentinel events. The direct observation audits completed by assistant nurse managers of bedside reporting being completed would be another quantitative evaluation. A report is being completed, the assistant nurse managers would be responsible for walking up and down the hallways, directly observing both the off-going and oncoming nurses completing the standardized method. It would be noted who was and was not completed as indicated. The first time that it would be noted that it was not being completed it would be a gentle reminder and education that this is standard practice, and it needs to be completed. Additional notes of noncompliance would result in disciplinary action. The audit would be completed weekly. Once the first month of implementation has been completed, assistant nurse managers would collect the statistical data on falls, medication, and sentinel events. The collection of data would be completed monthly. The

subjective determination of what worked and what did not can be determined directly through the surveys completed by the nurses and patients. This would directly ask for opinions on the standardization of bedside reporting, the education that was given, and ways the standardization could be improved. While it will be impossible to meet the desires of all involved with standardization, it is important to hear the opinions and take them into consideration when implementing changes. The survey would be completed monthly.

Summary

This MSN project will take approximately 1 month to conduct all of the necessary research needed to be able to adequately provide the education needed for success. With a budget of around $400 per unit, the Project Leader will develop the appropriate educational material and prototypes needed to promote the project to the unit stakeholders and then to the assistant nurse managers. After the staff has been educated, implementation will need to begin. With the necessary measures being taken to ensure compliance, medication errors, falls, and sentinel events will decrease by 40-50% and patient satisfaction will increase by 15-20%. The way this will be able to be measured is through qualitative and quantitative evaluations and surveys completed by patients and staff. With a timeline of approximately 5 months on the initial unit, each additional unit will require less time.

CHAPTER V

Dissemination

Bedside reporting is the best practice for handoff communication. It allows staff to hold each other accountable to ensure the patient is receiving the best care possible by both the oncoming and off-going staff members through direct collaboration. With patient safety as the main goal for all staff members, bedside reporting will facilitate just that. The goal and purpose of this MSN project are to decrease falls, medication errors, and sentinel events by 40-50% within 1 month, 100% of nurses on the unit will use the standardized method in their practice within 1 month, and patient satisfaction will increase by 15-20% within 1 month. The stakeholders that the project will be presented to will be the most vital part of the project to directly impact its results. If the stakeholder is not buying into the project details, it will be hard to ensure the longevity of the project itself. The stakeholder will be the manager from each unit. Each unit will involve individualized teaching and ideas since there are different managers with different ideas and perspectives. Ideally, there will be 100% compliance from all units in order to implement this MSN project hospital-wide and reach the highest potential for the community. With many different stakeholders involved, there will be many different perspectives on what needs to be changed or what could be done differently to improve the project. It will be the Project Leader's responsibility to ensure the changes suggested are changes necessary and maintain the core goals as the focus. Keeping the core goals as the focus in each meeting, the Project Leader will be able to ensure all units equally benefit from the project. The Project Leader will also take action to update and provide additional education and support to units following any changes made to the project as it

progresses through the units of the facility. With a new project, changes will inevitably be necessary, but it will be important to maintain the basis of the project goals.

Dissemination Activity

The project presentation was presented to the stakeholder, which is the nurse manager, two of the assistant nurse managers, and four staff nurses of the initial unit planned for implementation. It was announced to everyone on the unit that the Project Leader would be presenting this project and anyone from the unit was welcome to come. Those that attended the presentation were each given a copy of the PowerPoint presented, a copy of the developed brochure about bedside reporting, a copy of each patient and staff survey, the audit tool that would be used, and a copy of a prototype of the sign to be displayed outside of each patient's room following implementation. The PowerPoint presentation went through what bedside reporting is and the benefits of bedside reporting. The goals of the project were discussed. The organization that this was presented to already has the implementation of bedside reporting, however, no standardization was presented other than that it needed to be done. Since this was the case, the Project Leader went over the steps for best practice of bedside reporting. The steps discussed are as follows:

1. The nurse would introduce himself or herself and the oncoming nurse to the patient and visitors.
2. If there were any visitors present, the staff would ask the patient if the visitors can stay during handoff. If allowed to stay, then the report will begin; if not allowed to stay the nurse will ask visitors to step outside of the room.

3. The nurses will let those present know of the ability to ask questions and give input at any point during the report in their plan of care.
4. The oncoming nurse will update the whiteboard in the room with the names of the oncoming staff for the shift.
5. Handoff will be given in the room using the computer as a guide.
6. During the report, both nurses will assess intravenous (IV) lines, insertion sites, fluids infusing including labels and dates, tubes and drains, airway and oxygen, skin, wounds, and any incisions. The nurses will also assess safety portions such as the telemetry correctly being intact if applicable; microclimate therapy on the bed; all bed cords connected appropriately; alarms set on the bed; and signage such as falls, NPO, fluid restrictions, and precautions.
7. The off-going nurse would address any concerns or questions from the oncoming nurse, patient, and potential visitors.
8. The final step would be that the off-going nurse would document the nursing report on the computer, including adding the off-going nurse's name, the oncoming nurse's name, the method of transportation for the patient, any alarms, and patient belongings at the bedside.

The PowerPoint presentation then went on to discuss the new concept of bedside reporting explored by this MSN project. The MSN Project's concept of bedside reporting aims to ensure the patient is properly educated on bedside reports and what they are involved in. The patient would be asked once a shift during the nurse's initial assessment if the patient would like to be included in bedside reporting. If the patient states yes, it

would be charted in the Flowsheet and green would be displayed outside the room. The report for this patient would remain the same as current practice, the staff would need to ensure that green is displayed outside of the room, and ensure the patient is asked upon every initial assessment if they would like to remain involved in upcoming bedside reporting. If the patient states no, it would be charted in the Flowsheet and red would be displayed outside the room. The report for this patient would be outside the room at the doorway, the staff would need to ensure that red is displayed outside of the room, and ensure the patient is asked upon every initial assessment regarding involvement in upcoming bedside reporting. The nurse would still be responsible for assessing all above mentions aspects of patient care, condition, and status, including safety and signage. The exception to this situation would be if the patient is confused, on suicide precautions, or ventilated. For this patient, bedside reporting is not an option.

The timeline, supplies needed for implementation, a prototype of the laminated circle, and how the staff will be educated were all presented and discussed. The Assistant Nurse Managers are to primarily provide the staff education. The Assistant Nurse Managers were provided with the link to the PowerPoint presentation, brochure handout, and a prototype of the laminated circle. They were also provided with the link as well as a hard copy of each for them to provide to the staff.

It was discussed with the nursing staff present what would be expected of them. It also addressed how each can ensure the success of the MSN project. The assistant nurse managers were informed of the requirement to complete weekly audits on the staff for the first month of implementation and were provided with a standardized audit sheet to be completed. After 1 month of implementation, the nurses and patients will be given a

questionnaire with 1 week to complete. The assistant nurse managers were given a standardized questionnaire for both the staff and patients. Once all of the questionnaires had been resubmitted, the Project Leader will be given 1 week to make changes, in conjunction with the nurse manager and assistant nurse managers, in order to make the project sustainable. An additional month of observation and auditing will be needed prior to hospital-wide implementation. After the presentation was completed, the manager, assistant nurse managers, and nurses from the floor were given the opportunity to as the Project Leader any questions.

The feedback provided by the manager, assistant nurse managers, and nurses was extremely positive. Each was very engaged the entire time asking questions about the new process and how it would be beneficial to the unit. Each was very appreciative of a standardized method to complete bedside reporting itself, as well as the new ideas to directly involve patients. Stakeholders stated complaints heard the most about bedside reporting currently is that the patients had been woken up all night for patient care and being woken up again to be involved in the report was unnecessary. Stakeholders also reported many of the patients would prefer to be involved in the 1900 report because many of their tests and procedures occur during the day shift and this is the information pertinent to the patient's plan of care. Allowing patients this option with the new standardized method would resolve some issues presented by the patients.

A concern that was presented to the Project Leader was that the prototype laminated circle might be easily lost because of its size. This is something that the Project Leader was concerned about because it was hard to estimate an appropriate size for the outside of the doors. It is also something that can and will be easily fixed by the Project

Leader. The Project Leader asked for a suggested size and the nurse manager, assistant nurse manager, and nurses all agreed the circle should be the size of about a half sheet of paper. Another concern addressed was that the goal percentages might not reflect as soon as the Project Leader had hoped. Stakeholders believed patient satisfaction would be difficult to measure due to uncontrollable circumstances beyond the logistics of the project. Another concern presented is that it might be difficult to measure something like medication errors and sentinel events that were found because of a fear to report. It would be important for the assistant nurse managers to ensure their nursing staff that no matter what, medication errors and sentinel events need to be reported for the safety of the patients. The changes the Project Leader would consider could be discussed after the first month of implementation. The first month would be considered a trial run to see what the statistics looked like after the implementation and prior to implementation and compared. The goal numbers would also be looked at and compared to these numbers and changes made accordingly.

The nurse manager asked the staff, assistant managers, and the Project Leader what the biggest concern was as to why bedside reporting was not being done even though it was supposed to already be implemented within the organization. The consensus of this was a lack of education for the patient on exactly what bedside reporting was and what it entails. Many times, the nurses will go in and do bedside reporting but not explicitly indicate what is being performed and if the patient is asked later if it was completed the answer will be no. A greater change that could be implemented with this project would be placing the emphasis on patient education of bedside reporting and the patient's role in the process. The final concern presented by the

nurse manager was who exactly would be doing the auditing if the assistant nurse managers were pulled into staffing and not available for office time. The Project Leader proposed that if the assistant nurse managers were not in the office, it would become the responsibility of the off-going charge nurse. In this particular unit, it is customary for the charge nurse to arrive 30 minutes before the shift begins in order to transition smoothly from shift to shift. Since the charge nurse will be done reporting to the oncoming charge nurse while the staff is giving a report, the off-going charge nurse could be responsible for audits. This would leave the ongoing charge nurse available to watch the heart monitors while also being available to answer questions and help with anything that might occur during shift change.

Limitations

Limitations do exist for every project that is created or developed, but definitely for new projects. The Project Leader quickly learned this statement during the developing stages of this MSN Project. There are many moving parts to any new thing and taking them all on independently can present a difficult task. In a perfect world, there would be an unlimited amount of time for research, presentation of ideas, and making necessary changes; however, reality presents challenges.

Another limitation that could have been addressed is a baseline assessment of the number of falls, medication errors, sentinel events, nurse compliance with bedside reporting, and patient satisfaction percentage. These numbers could have helped to better determine the goal percentages. This was not addressed directly within the MSN Project because regardless of what the numbers were prior to implementation of this project,

every unit could use improvement of each of these numbers until there are no medication errors, falls, and sentinel events throughout.

Implications for Nursing

This MSN Project is extremely significant to the current nursing profession. Bedside reporting is the best practice for every staff member in a direct patient care area. At this specific organization, the MSN Project is being presented, and bedside reporting is already implemented, there is just no standardized way of doing so. This seemed to be the commonality found in research completed throughout this MSN Project. Bedside reporting is significant to today's nursing practice, as it should always be because no nurse wants any harm to occur to patients. The goal of bedside reporting is just that, patient safety and to do no harm. The main ideas that go along with this specific MSN Project are a decrease in falls, medication errors, and sentinel events. By completing bedside reporting, nurses are held to a higher standard to ensure the patients receive the best care possible. Holding each other responsible for providing the best care possible, increases rapport between the nurses and patients. There is also an increase in opportunities to include patients in plans of care. Giving patients greater opportunities to be included in plans of care, will create an environment of autonomy for the patients when making medical decisions. Patients can feel much more confident making decisions with plans of care knowing they are directly involved in all aspects of their care. The future practice implications should be similar to that of the current nursing profession. While the specifics of each bedside report will change as time goes on, the basis will remain.

Recommendations

The greatest problem that arises in the area of bedside reporting is the longevity of compliance. Throughout all of the studies researched in the literature review, the common noted concern was staff compliance over time. Time and time again throughout the research, it has been shown that staff is reluctant to change. It would be important that if staff remain reluctant to change with this new MSN Project, to address rationales. The first time the staff is not found to be compliant, it would be important to re-educate on the importance of why this is being done and why it is important it is completed. A second-time staff is found to not be compliant, the assistant nurse managers would be responsible for addressing it personally in a more intimate setting. A third time the staff is found to not be compliant, disciplinary action will be taken. If they are found to continue to be non-compliant, this is when the stakeholder, assistant nurse manager, or Project Leader could sit down with them and directly ask why they are resistant to the change and why they are not compliant with something that is required.

Another problem that could be addressed is the lack of patient education. This MSN Project has stated patient education needs to be completed, but there are no specifics mentioned as to how to go about this. During the dissemination of this MSN Project, it was mentioned there is an existing gap between the organization's version of bedside reporting and the education being completed for patients. The MSN Project could be greatly improved by placing a greater emphasis on patient education altogether. Many times, reporting is being completed at the bedside but if leadership were to audit the patient and ask if bedside reporting was complete, the patient may say no because due to being unaware of bedside reporting.

Conclusion

This MSN Project has been an eye-opening experience through the journey of research for the nurses as well as the patients. Research has shown the most success with bedside reporting being completed. It creates a greater bond between the nurse and the patient by making the patient feel directly involved in plans of care. This can tend to ease any frustrations that can occur from a lack of communication between medical staff and the patient that is often occurring. If bedside reporting is not conducted, the patient can feel removed from the plan of care or abandoned for a period of time between shifts. This time between shifts is a prime time for a potential mistake to occur. This period could sometimes be anywhere from 1-3 hours between the time the last shift's nurse cared for the patient and the oncoming shift coming in to do an initial assessment and provide care. This amount of time should never elapse without someone being in the room, ensuring the patient's safety is maintained. The bottom line is that bedside reporting is what is the safest and best practice for the nursing community. Dingley et al. (2008) write, "Current research indicates that ineffective communication among health care professionals is one of the leading causes of medical errors and patient harm. A review of reports from the Joint Commission reveals that communication failures were implicated at the root of over 70% of sentinel events." These are all problems that could be directly addressed during bedside reporting. All research points back to, while bedside reporting takes more time, it is the safest and most effective way to display information from shift to shift. Rush (2012) stated it best, "instituting bedside reporting allows nurses to positively impact patient and family experiences. It puts patients at the center of communication and permits them to collaborate and participate in their own recovery. Bedside reporting

encourages teamwork and accountability of staff and is safer for the patient because it increases the quality of hospital care." Bedside reporting works directly for the safety of the patients, staff just have to remain compliant and communicable with their teammates.

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