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Journey to the Bedside: A Quality Improvement Project to Implement Bedside Report Utilizing Watson's Theory of Human Caring

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by

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Abstract

A 134 bed hospital in a rural community had a continuous struggle to meet defined goals on the hospital consumer assessment of healthcare providers and systems survey (HCAHPS). The hospital's medical unit consistently performed lower in the c*ommunication with nurses* HCAHPS domain than other nursing departments in the organizations. Between 2015 and 2017 the overall *communication with nurse's* score in the HCAHPS domain of the medical unit ranged between 74-79%. Nursing staff were task oriented, focusing on the next task to be done instead of the current moment and interaction with the patient. A literature review revealed that consistent themes involving patient communication, nurse satisfaction, intensity of patient illnesses, and hospital marketability all have an impact on HCAHPS. Patient perceptions of care and interactions with nurses emerged as the most dominant theme found in the evidence demonstrating this as an important focus of the intervention to address the indicated problem. Many best practices were recognized in the literature as having a positive impact on patient satisfaction, however bedside reporting addressed all of the critical elements of the nurse patient relationship. An analysis of the literature review showed supportive evidence that bedside reporting would have a positive impact on the communication with nurse's domain in HCAHPS. A bedside report intervention implemented utilizing the participatory model and guided by caring science produced key findings which demonstrated positive outcomes for patients, staff, and the organization. The participatory model allowed the bedside report process to be designed based on frontline staff members' knowledge of the actual unit workflow. The early identification of potential barriers by the bedside report team also allowed for the team members to

participate and lead staff engagement initiatives based on caring science. The Communication with Nurses domain in HCAHPS indicated an overall positive increase from 70.9% to 89.0% of patient indicating the top score of "always". Data from the key question within the *Communication with Nurses* Domain in HCAHPS *Nurses listened carefully to you* indicated an increase from 68.3% to 85% of patients indicating the top score of "always" and data from the question *Nurses explained things in ways you understand* indicated an increase from 63.9% to 81.3% of patients selecting the top score of "always" According to the Watson Caritas Patient Survey Tool results, patients perceived that staff always met their needs with caring kindness over 90% of the time (n=103). A Staff Perception of Bedside Report survey (n=60) designed by the project leader indicated that staff perceived the bedside report process created a caring encounter between nursing and improved communication between staff and patients. Managing interruptions and patient needs during the bedside report were found to be important for successful implementation and workflow. The use of participatory model and a caring science concepts and a structured timeline allowed for staff collaboration, staff preparation, successful implementation, staff engagement, and plans for sustainability.

Acknowledgements

Completing this project has been a collaborative effort that was only possible through the time and devotion of many family, friends, and colleagues. Thank you to my family for the understanding and sacrifices over the past two years. Your patience and encouragement has sustained me throughout this journey. To the members of the bedside report team and my project partner, your efforts and dedication to this project demonstrated a professional commitment to both patients and peers. Thank you for the ideas and support in reaching this project goal. I share this achievement with each of you. My deep appreciation is extended to Dr. Gayle Casterline. Without her promotion, encouragement, and guidance throughout this process the success and completion of this project would not have been possible. Lastly, thank you to the staff and graduate faculty at Gardner-Webb University Hunt School of Nursing. Through the DNP curriculum, you have instilled a strong foundation for both leadership and practice for the DNP role and its importance to the nursing profession.

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SECTION I

INTRODUCTION

To remain successful in today's health care market, nursing leadership within an organization must promote a culture that has a positive impact on the patient experience. The hospital consumer assessment of healthcare providers and systems survey (HCAHPS) provides feedback to hospitals to gauge the positive or negative impact on overall patient satisfaction. The purpose of the project will focus on the HCAHPS scores of a 42-bed medical unit in a rural hospital setting, which have been a consistent challenge at both the organizational and departmental level. The consistent poor performance on HCAHPS has created a task-oriented work environment and lack of connection to the patient care. The utilization of an evidence-based practice implemented through caring science to impact nurse and patient communication and caring encounters will be applied to the problem with results and outcomes discussed.

Background and Implication of Problem

HCAHPS is a national standardized survey, conducted on behalf of the Center for Medicare and Medicaid Services (CMS), which publicly reports patient's perspectives of care received during hospitalizations. For the first time in the history of healthcare, patients are given a voice as to their "patient experience". The overall goal of the HCAHPS survey was to provide consumers with information that might be helpful in choosing a hospital. The survey questions include the following areas: *Communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medications, cleanliness of hospital environment, quietness of*

hospital environment, discharge information, overall hospital rating, and likelihood to recommend.

Background

With the implementation of the Affordable Care Act and value-based purchasing, hospitals must meet certain scores on the HCAHPS patient survey to obtain top level reimbursement. The patient experience is a complex domain impacted by elements such as outcomes, trust, and communication. Negative impacts to the patient experience could result in financial losses for health care organizations totaling in the millions. The quality of care provided to patients and families is now being measured as patient satisfaction. Essentially the patient's experience is tied directly to the financial viability of the health care organization (Wolosin, Ayala, & Fulton, 2012). The empowerment of the patient experience and feeling cared for results in a major impact to hospitals due to a potential reduction in revenue. This may lead to job losses for the community, a reduction in budget spending for needed equipment, and possibly the closing of the facility creating an access to healthcare problem for the community. This can particularly impact rural hospitals who already have limited financial resources (Kavanagh, Abusalern, & Coty, 2013). Positive outcomes in patient care are connected to hospital financial viability through the need for accessible continued services to local populations.

Organizational Impact

The current organization setting for the problem is a rural 134 bed hospital which is part of a larger health system located in North Carolina. Each facility within the system has HCAHPS goals. Weekly HCAHPS data is compared both within and outside of the organization. A continuous struggle to meet HCAHPS goals has resulted in staff

nurse perceptions of a punitive and reactive environment. Perceptions of care on the medical unit are driven by the weekly changes in the HCAHPS scores. These perceptions are communicated to the management team of the medical unit on a daily basis from both nursing staff and hospital administration. This has resulted in a non-focused approach to problem solving, which changes based on weekly HCAHPS data. The search for quick fixes for HCAHPS scores on the medical unit has led to organizational frustration. This has resulted in continued attempts to implement solutions that do not allow for an appropriate timeline for the change process, leader, or staff engagement to the intervention.

An example of this is hourly rounding which was mandated over two years ago but has not been incorporated into staff workflow, is seen by staff has a "task", has not been sustained, and thus has had little impact on HCAHPS scores for the medical unit. This has impacted both the stress and morale of the nursing staff. In the overall picture of the organization, the struggle to connect and meet expectations of patients admitted with acute and/or chronic medical illnesses is presenting a challenge which impacts a large population of the patients and staff who are key stakeholders in the organization.

Staff Impact

One nurse on the medical unit described the ongoing battle to improve HCAHPS scores as "constantly taking two steps forward and three steps back, only to find yourself right back where you started." Each week as new scores come in the staff anxiously reviews the board. A mix of excitement, anger, and frustration is usually the result as the scores show no predictable consistency. Staff on the medical unit verbalize many workflow issues they feel contribute to current HCAHPS scores such as shift report

communication, nurse to patient ratios, patient turnover, and ability to spend time in patient rooms. Due to the high patient volumes and turnover, the nursing staff are task oriented, focusing on the next task to be done instead of the current moment, and interaction with the patient. The consistent pressure from administration regarding the low HCAHPS scores for the department has resulted in additional stress and turnover for the department. Many nursing staff are leaving or transferring to areas where HCAHPS is not a determining factor that is utilized to judge the overall care. Most of the nursing staff feel the scores are unfair and do not truly reflect the patient care. These ongoing problems have resulted in a disconnect and lack of engagement to interventions such as hourly rounding with nurses citing that due to interruptions it is hard to consistently incorporate and structure into the workflow of the shift. This disconnect is evident through observation of the nursing routine, handoff, and staff/patient interactions throughout the shift. The interactions are polite, superficial and appear reactionary to a patient request, or routine care task.

Patient Impact

The patient's voice speaks volumes on the HCAHPS scores for the medical unit. As the data shows, key areas such as listening, explaining things in ways the patient can understand, and communication about medications greatly underperforms when compared to the surgical population. Is there a greater expectation from the medical patient population related to these key issues? A review of patient comments from HCAHPS data, variance reports, and service issues reveal a consistent problem with handoff communication and providing updates to the patient and families related to the plan of care. This disconnect between the task-oriented workflow of the nursing staff,

and the patient need for focused attention, listening, explanation, and communication is a distinct barrier to improving HCAHPS scores. Comorbidities of patients admitted to the medical service create an increased complexity of care related to treatment plans and acuity. Upon admission, patients are faced with changes to their routine medications regimes along with multiple questions, tests, and treatments. This creates an atmosphere for potential patient dissatisfaction. The current nursing workflow does not allow for structured interactions that consistently address the communication needs required by the medical patient population.

Evidence of the Problem

Problem Setting

The setting for the defined problem is a 42-bed medical unit located within a 134-bed rural hospital in the Southeastern United States. The medical unit is the largest of the nursing units with a 95% adult population and a 5% pediatric population. The patient population served on the medical unit is experiencing acute symptoms of medical illnesses requiring admission to the hospital.

Overall HCAHPS Data

The overall *likelihood to recommend* score for the organization has not reached over 72% from 2015 to 2017 with the goal being 85% (Press Ganey, 2017). The two largest inpatient populations are admitted to the medical unit and the surgical inpatient unit. The surgical inpatient unit is a 16-bed unit significantly smaller than the medical telemetry unit. The likelihood to recommend score for the surgical unit from 2015-2017 has ranged from 65% to 75%, while the likelihood to recommend score for the medical unit from 2015-2017 has ranged from 50%-59% (Press Ganey, 2017). Both units had

HCAHPS return rates of approximately 200 surveys for 2015 and 2016. The return rate for the surgical unit was over 70% of the total population, with the medical unit having a significantly lower return rate of just 30%. The HCAHPS scores of the medical unit resulted in a decline of the overall HCAHPS ranking for the organization in 2015 and 2016(Press Ganey, 2017).

Communication with Nurses Data

The overall *communication with nurses* domain scores from 2015-2017 show differences between the medical telemetry unit and the surgical inpatient unit. The overall scores for the medical unit were consistently lower. This is shown in Figure 1.

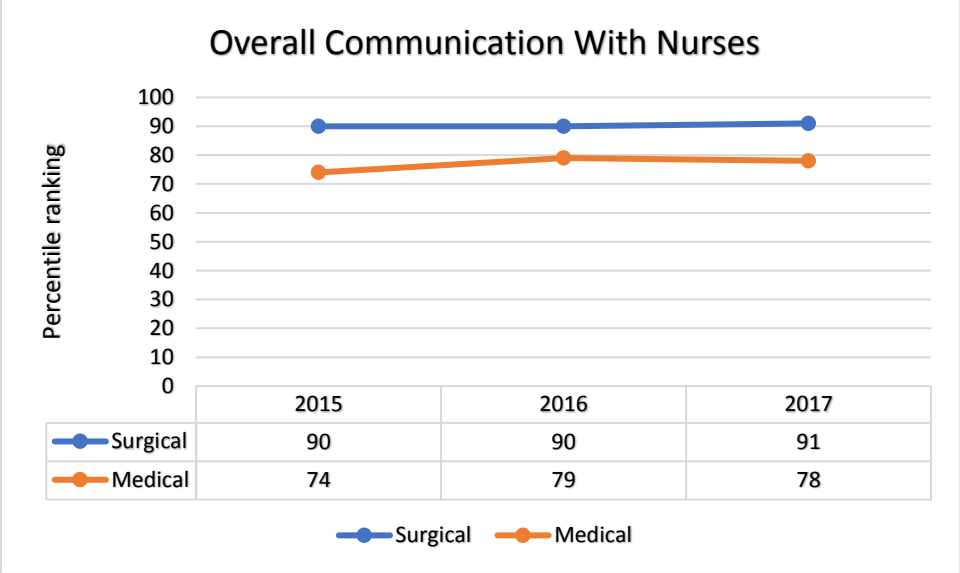

Figure 1. Overall Communication with Nurses. Compares HCAHPS Communication with Nurses Scores between the Medical and Surgical Units.

Percentile data for the two key questions within the *communications with nurses* HCAHPS *domain nurses listened carefully to you,* and *nurses explained in ways you understand* for the medical and surgical units are demonstrated below in Table 1. The medical unit consistently performed lower in both key areas.

Table 1

Communication with Nurses Question Percentage Scores for Surgical and Medical Units

Question	Surgical Unit		Medical Unit	
Nurses listen carefully to you?	2015	94%	2015	69%
Nurses explained in ways you	2016	94%	2016	74%
understand?	2017	90%	2017	68%

Note. Based on HCAHPS survey data received 2015, 2016, and Jan-May 2017. Percentage indicates "top box" rankings.

Refining the Problem

Of the adult population admitted to the medical unit, organizational statistics show that 77% of this population has at least one diagnosed chronic disease in addition to the admitting diagnosis for the inpatient stay. The medical unit serves an overall older population with an average age of 72 who have at least one chronic disease. Evidence has shown that patients with chronic disease have an increased need for involvement in their plan of care and a strong desire to be listened to by their providers (Griscti, Aston, Misener, Mcleod, & Warner, 2016). The perception of care is strongly connected to effective communication and care interactions between the patient and nurse (McClelland & Vogus, 2014). This equates to how the patient views the quality of care, which impacts nursing HCAHPS domain scores and the overall HCAHPS scores for the organization. This cascade effect is demonstrated below in Figure 2.

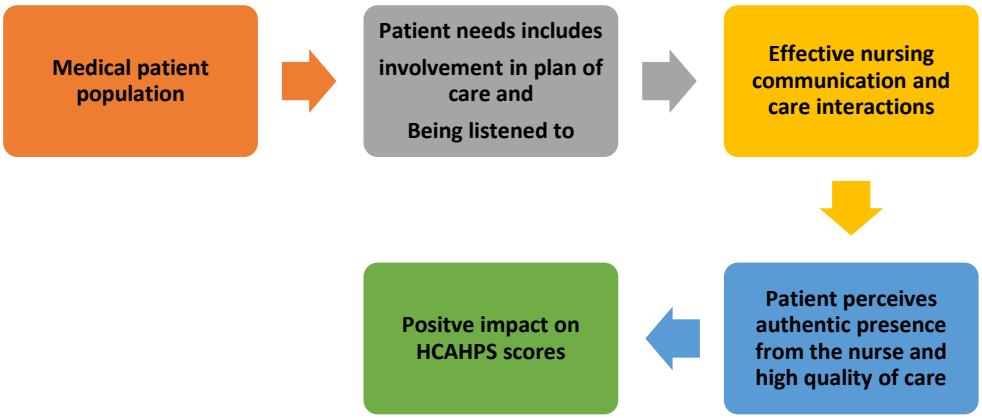

Figure 2. Cascade of Patient Perceptions on HCAHPS. Shows How High Patient Perception of Quality of Care Cascades to a Positive Impact on HCAHPS Scores.

Direct observation and staff interviews have shown that patient acuity, census, high patient turnover, and nurse to patient ratios in the medical telemetry unit have resulted in a nursing workflow that task-oriented. Instead of being focused on the current patient interaction or moment of care, the nurses are focused on the next task to be completed. The task-oriented nursing workflow is in direct conflict with the communication needs of the medical patient population and can result in negative perceptions by the patient as illustrated in Figure 3.

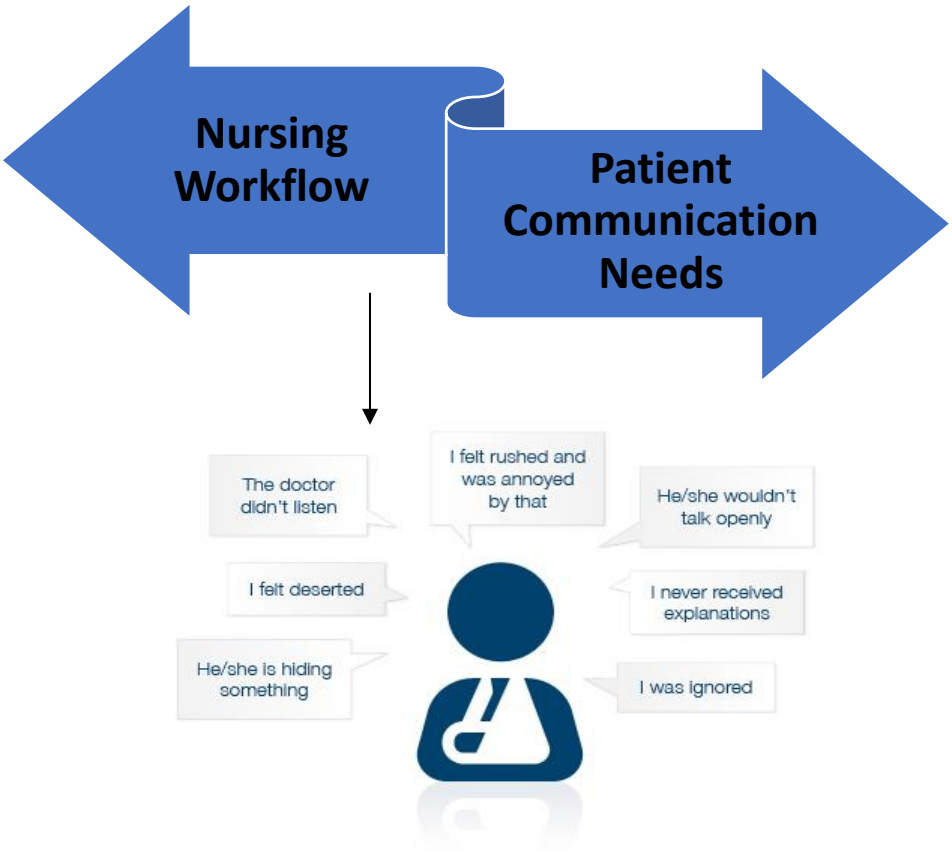

Figure 3. Opposing Forces Nursing Workflow and Patient Communication. Shows the Opposing Forces of the Nursing Workflow on the Medical Unit and Communication Needs of the Medical Population and Resulting Negative Patient Perceptions.

SECTION II

LITERATURE REVIEW

A literature review was conducted for the purpose of exploring the identified problem between nursing workflow and the communication needs of the patient. The literature review evidence is presented below including the search methods, and relevance to the organizational, patient, and nursing components. Key search terms included HCAHPS, patient satisfaction, chronic illness, hospitalization, nursing engagement, perceptions of hospital care, and comorbidities related to patient satisfaction. Literature support is presented in three categories: organizational impact, patient impact and nursing impact.

Organizational Impact

For today's hospitals, patient satisfaction can bring big rewards and recognitions, or big penalties and financial instability. Although hospitals have always been in the business of care, the measurement of successful patient care delivery has been redefined with a shift to focus on the patient experience (Kavanagh et al., 2013). The organizational implications for hospitals are significant in the marketability of services. Hubbertz and Carlson (2010) reported a direct link between HCAHPS scores and profitability and indicated that from 3,035 US acute care hospitals, the top 25 that scored the highest on HCAHPS were also the most profitable. Key to the profitability of hospitals is marketability. In a quantitative random sampling of patients of a large university health system Hubbertz AND Carlson (2010) found that consumer information regarding HCAHPS scores greatly impacted consumer choice. Patients sampled were asked what impacted their choice of hospitals for non-emergent care. Over 60% of the

patients sampled indicated they based their decisions on word-of-mouth opinions from other individuals. An interesting note on this study was that less than 20% of the patients sampled stated they actually looked at satisfaction scores on the HCAHPS website but instead went by opinions of others who had indicated the influence of word-of-mouth marketing.

Organizational support to optimize the patient experience is another key component of higher HCAHPS scores. A correlation between higher HCAHPS scores and administrative support for the nursing work environment was reported by Wolosin et al. (2012). In a logistical regression analysis of random sampling of HCAHPS survey scores, hospitals were compared based on HCAHPS performance, and nurse engagement scores from a sampling of over 300 nurses employed by three different hospitals within a single health system. The hospitals that performed the highest on the nurse engagement survey also performed the highest on HCAHPS scores. Findings indicated that a positive nursing work environment resulted in higher patient satisfaction and higher HCAHPS scores. This was further supported in the literature by Berkowitz (2016). In a collective review of studies related to measurement of patient satisfaction, findings supported that care collaboration, communication, and patient/staff interaction greatly impact how patient satisfaction is scored. The literature review which consisted of nine different studies also showed that hospital leadership supporting collaboration of care within the organization results in increased levels of patient satisfaction (Berkowitz, 2016). Collectively, the findings indicated that organizational support of evidence-based practice is necessary to achieve the important mandates of staff collaboration, communication, and engagement necessary for patient satisfaction.

Patient Impact

HCAHPS measures the perception of the patient's hospital experience. Perceptions are unique to individuals driven by emotion, personality, and stressors (Kavanagh et al., 2013). Understanding what drives these perceptions is necessary in improving HCAHPS scores. Patients who have chronic health problems have unique and special needs that must be incorporated into effective evidence-based practice interventions for the nursing workflow. Otani, Waterman, Dunagan, and Ehinger (2012) found that the severity of illness of a patient, determined by overall length of stay and level of care, resulted in significantly overall lower HCAHPS scores. In a case controlled study using a mathematical non-compensatory model, patient satisfaction scores were compared based on whether the patient had experienced critical care during their stay. Over 300 patient satisfaction scores of a five hospital rural system were correlated to the patient's severity of illness. Findings indicated that the more severe the patient illness, the lower the patient scores specifically in areas of communication and responsiveness. These findings were further substantiated with a study by Wennberg, Bronner, Skibner, Fisher, and Goodman (2009) who correlated patient satisfaction scores to the number of co-morbidities listed in the patient diagnosis. Using a survey methodology of HCAHPS data on 700 patients of a large hospital system the study found that patients with two or more co-morbidities consistently ranked HCAHPS scores lower in the key domains of communication and likelihood to recommend.

In identifying what is important to patients during a hospital stay researchers found that personal interaction, listening, and respect were important to the patient for effective collaborative care (Griscti et al., 2016). In a theoretical and methodological

approach of in-depth interviews of over 87 patient and nurse participants, key terms were identified as being important to the patient experience including listening, bonding, and respect. A key finding of this study was that these terms were similar in both patient and nurse interviews. Communication was also found to be significant in a study by Lamas et al. (2017). The study aimed to explore the expectations of care goals for the chronically ill patient. Although limited to a sample size of 23 participating patients, the study found that communication was the top priority of patients who had chronic illnesses that required frequent use of the healthcare system. Lamas et al. (2017) demonstrated that chronically ill patients felt that treatment plan updates and expected prognosis were important factors in patient satisfaction. How patients perceived caring behavior was examined by Ashish, Orav, and Epstein (2008). Utilizing the HCAHPS scores and a quality assurance questionnaire, over 100 patients were asked to reflect on their hospital stay and what influenced their patient satisfaction scores. Results indicated that caring behaviors most impacted how the patient perceived their hospital stay which were reflected in HCAHPS scores (Ashish et al., 2008). Collectively, these studies indicated a very specific need for caring, collaborative behavior, and communication from staff involving and informing the patient on the plan of care.

Nursing Impact

Nursing is at the center of the patient experience revolution. Studies have indicated that engagement of nursing staff results in over 50% higher HCAHPS scores (Wolosin et al., 2012). For most patients, nursing embodies the concept of caring, which sets the overall standard for the patient's hospital stay. Through this perception, nursing obtains a level of power and influence over HCAHPS scores that seemed to be far above

any other discipline within the health care organization ("The Rising Tide Measure," 2013). The literature supports nursing's impact on patient satisfaction. In a cross-sectional study, McClelland and Vogus (2014) specifically looked at how compassionate care practices of nursing staff impacted HCAHPS rankings related *to likelihood to recommend*. Prior to discharge from various nursing units across the system, over 200 patients were sampled as to the level of compassion they perceived during their hospital stay. This was later correlated to the patient's HCAHPS scoring of the same hospital stay. There was a discrepancy as to the number of patient surveys obtained prior to discharge, and the number who actually responded to the HCAHPS survey by over 40%. However findings did indicate that compassionate practices by nurses greatly influenced the patient's perception of the quality of care and the *likelihood to recommend* ranking of the hospital. Personal touch, communication and scripting were explored by Seeber (2012) as to how these human expressions impacted patient satisfaction. In a quantitative study using an experimental model of care, Seeber (2012) utilized med-surg units of a three hospital system to implement nurse scripting, compassionate touch, and communication interventions during purposeful rounding by the nursing staff. Patient satisfaction scores were then reviewed pre and post implementation. Findings indicated a positive impact on patient satisfaction scores by over 37% after a three month time-frame.

The connection to the nursing work environment to patient satisfaction was explored by Kieft, De Bouwer, Francke, and Deinoij (2014) which showed the positive correlation between positive work environments to higher patient satisfaction scores. Using a descriptive qualitative research design with four focus groups, the authors found

that autonomous nursing practice, adequate staffing and managerial support contributed to nurses' view of positive patient interactions, communication, and overall experience. Lee et al. (2009) explored the positive and negative influences of nurse staffing to patient satisfaction. Using cross-sectional data from three sources including HCAHPS, nursing survey, and an American Hospital Survey (AHA), the study explored in detail the relationship between the nursing work environment, staffing levels, and HCAHPS. Although sample size was undisclosed, findings were reported that indicate hospitals must address the issues of nursing work environment and staffing levels to achieve positive HCAHPS scores. The growing impact of nursing on overall HCAHPS scores was supported by a survey conducted by Press Ganey. In the article *The Rising Tide*, Press Ganey detailed a hierarchical variable clustering analysis of over 2,000 patient surveys and found that performance in the *communication with nurses* domain strongly influenced four other HCAHPS domains ("The Rising Tide Measure," 2013).

O'nan, Jackson, Morgan, and Adams (2014) demonstrated how delivery of care models based on theoretical frameworks of caring positively impacted patient satisfaction outcomes. Duffy's Quality Caring Model was implemented in three separate med/surg/telemetry units in a large academic medical center. Using an evaluation design the patient perception of caring was compared pre and post implementation of the caring model. Findings indicated that the model was effective in positively impacting the perception of the nurse/patient interaction and the patient's perception of caring (O'nan et al., 2014). Overall the evidence indicates that nursing is the dominating force behind improving HCAHPS scores.

Overall the evidence points to a chain of components that must be linked together to achieve patient satisfaction demonstrated below in Figure 4.

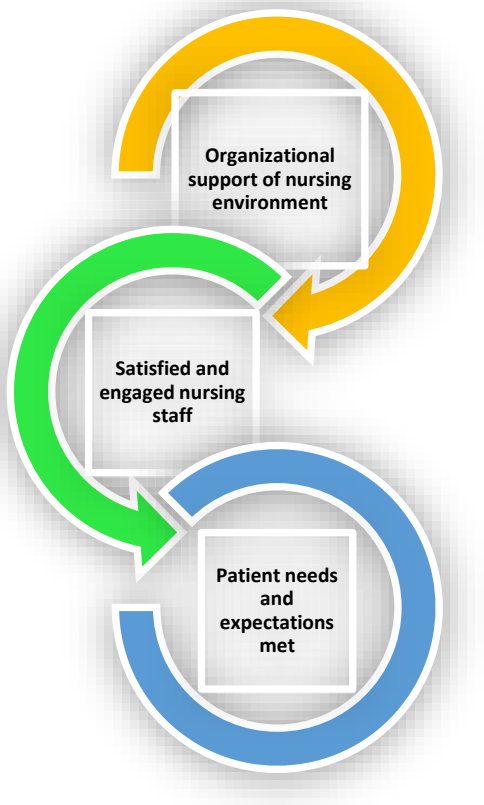

Figure 4. Chain of Components for Patient Satisfaction. Shows the Chain of Components Necessary for Patient Satisfaction.

Organizational support for the nursing environment, which leads to engaged and satisfied nursing staff, which leads to meeting patient needs and expectations was all found in the literature review. The summary of evidence is presented in the literature matrix in Table 2.

Table 2

Literature Review of Supportive Evidence for Problem

Citation	Research Design and Method	Conceptual Framework	Conclusions	Implications to Practice	Study Limitations
(Otani, Watermann, Dunagan, & Ehinger, 2012)	Case controlled study using a mathematical non-compensatory model	How do seriously ill patients differ from less seriously ill patients when answering a patient satisfaction survey, and does this impact the patient experience and likelihood to recommend?	The results revealed that the severity of illness measure is a significant factor for patients when Responding to a survey	The results demonstrated practical implications for healthcare staff and management by showing what influential factors impacted patient satisfaction with severely and chronically ill patients	Study same limitations to geographical region, did not account for other variables of respondents
(Hubbertz & Carlon, 2010)	Quantitative with random sampling	To investigate the impact of the HCAHPS report of patient experience and word-of-mouth narratives on consumer's hospital choices	Findings indicate that available consumer information impacts hospital choice	Practice implications include the importance of consumer information and marketing related to market share and competitiveness for hospitals.	Limited sample geographical region, lack of participation of rural hospitals
(Wolosin, Ayala, & Fulton, 2012)	Logistical regression analysis of random sampling of HCAHPS survey scores	The study objective was to investigate how domains of patient satisfaction in hospitals predict HCAHPS scores and reimbursement changes	The findings how that hospitals focusing on HCAHPS overall satisfaction would likely see the greatest impact by engaging in improvements to nursing care	Study shows the actual impact of nursing on the top box ranking of HCAHPS scores. This indicates financial impact on organization of nursing care	Limited sample size and geographical location

Citation	Research Design and Method	Conceptual Framework	Conclusions	Implications to Practice	Study Limitations
(McClelland & Vogus, 2014)	Cross-sectional study	The study objective is to examine the benefits of compassion practices on two indicators of the HCAHPS survey including hospital ranking and likelihood to recommend.	The study finds that patient perceptions of care quality are associated with a set of concrete organizational practices that foster a compassionate care environment and culture by nursing	Practice implications show the effective use of compassion practices for both staff and patients to positively impact HCAHPS scores.	Sample size and limited study settings
(Seeber, 2012)	Quantitative study using an experimental model of care	Would a model of care based on consistent nurse scripting, communication and physical touch impact patient satisfaction and reduce call lights?	Findings support the positive impact of the "kind peace of mind culture" model of care	Practice application shows interventions such as personal touch, nurse scripting, and communication are effective tools for improving patient satisfaction	Study setting limitations to 3 hospitals in geographical location
(Berkowitz, 2016)	Collective review of studies related to measurement of patient satisfaction	How to effectively measure and understand the complexity of the patient experience	Findings of all studies support that care collaboration, communication, and patient/staff interaction greatly impact how patient satisfaction is scored	Guides the design of interaction that incorporate collaboration, communication, and patient interaction to positively impact HCAHPS scores	Individual studies each limited to single hospital settings No specific explanation on staff interventions on communication
(Kieft, De Bouwer, Francke, & Deinoij, 2014)	Descriptive qualitative research design with focused groups	To comprehend the views of nurses on how their work and work environment contributed to positive patient experiences	The research found that autonomous nursing practice, adequate staffing and managerial support contributed to nurse's view of positive patient interaction, communication, and overall experience	The results of the study validate the importance of shared governance, and transformational leadership methods to optimal patient and staff experience outcomes	Limited to only four focus groups Indicated only nurses views no patient views

Citation	Research Design and Method	Conceptual Framework	Conclusions	Implications to Practice	Study Limitations
(Lee et al., 2009)	Utilized cross-sectional data from three sources HCAHPS, nurse survey, and AHA survey	The study explores in detail the relationship between the nursing work environment, staffing levels, and HCAHPS	The study found that nursing work environment and staffing levels significantly impacted the key domains of communication with nurses and the likelihood to recommend the hospital	Hospitals must address the issues of nursing work environment and staffing levels to show positive outcomes on HCAHPS. This gives data to nursing leaders to address these issues	Cross-sectional design does not inform causation Sample size limited to hospitals who voluntarily submitted HCAHPS
("The rising tide," 2013)	Hierarchical variable clustering analysis	The study goal was to further demonstrate the importance of the nurse role in transforming the health care system and impacting HCAHPS domains	The study found that performance in the communication of nurse's domain strongly influences four other HCAHPS domains including likelihood to recommend and overall hospital rating	Bedside nursing care and overall communication has the power to impact financial viability of health care organizations through the patient experience	Limited to one hospital system consisting of 5 individual hospitals No specific information as to type and size of nursing units for study locations
(Wennberg, Bronner, Skibner, Fisher, & Goodman, 2009)	Survey methodology through utilization of HCAHPS data, and patient diagnosis data and focused group interviews	The study aimed to evaluate and compare the HCAHPS rating of key domains in communication and likelihood to recommend against the number of patient co-morbidities and intensity of patient illness	The study found that patients who has 2 or more comorbidities and a higher intensity of illness consistently ranked HCAHPS scores lower in the key domains of communication and likelihood to recommend.	This study shows a definite correlation between chronic illness and intensity of illness and low HCAHPS. This implies the need for additional or different interventions to achieve patient satisfaction with this patient type	Possible bias due to non-reporting and non-responding hospitals Limited reflection of disease severity of respondents
(Lamas et al., 2017)	Semi-structured interview methodology with analysis	The study aimed to explore the expectations of care goals for the chronically ill patient	The study found that communication was the top priority of this population especially related to discharge disposition, treatment plan, and expected prognosis	Validates the importance of communication and updates utilizing interventions such as AIDET (Acknowledge, Introduce, Duration, Expectation, and Thank You)	No specific indication as to patient population demographics or illness type

Citation	Research Design and Method	Conceptual Framework	Conclusions	Implications to Practice	Study Limitations
(Griscti, Aston, Misener, Mcleod, & Warner, 2016)	Theoretical and methodological approaches of in-depth interviews	The aim of this study was to examine the experiences of the chronically ill patient and registered nurses as they negotiated care in the hospital setting	The study found that personal interaction, "bonding", listening, and respect were key elements in the effective negotiation of care in the hospital	Patient involvement, communication, and listening are key to patient satisfaction of the chronically ill	Limited to single hospital system
(*O'nan, Jackson, Morgan, & Adams, 2014)*	Used an evaluation design with multiple data collection points	To measure the impact of implementing Duffy's quality caring model on patient's perception of caring on medical/surgical/telemetry units	The study found the model was effective in impacting the nurse/patient interaction and the patient perception of caring especially with patient satisfaction scores related to listening	Caring models and theories such as Duffy's are effective frameworks to design workflow and models of care around the patient centered relationship. The concept of caring greatly impacts patient satisfaction	Limited to one hospital system consisting of 3 individual hospitals
(Ashish et al., 2008)	Correlation of HCAHPS survey and Hospital Quality Assurance program survey, chi square and t-test	The study sought to examine the perceptions of care for acute hospitalized patients and how these perceptions impacted HCAHPS scores	The study found when completing the HCAHPS survey, patient reflect on their hospital stay and are influenced by the caring relationships encountered throughout their hospital experience	The study reinforces the importance of caring behaviors being incorporated into nursing interaction and workflow with patients	Limited to HCAHPS participating hospitals

Note. Presents evidence to support the identified problem related to communication with nurses, the medical population and HCAHPS.

Summary of the Evidence

Overall consistent themes involving patient communication, nurse satisfaction, intensity of patient illnesses and hospital marketability were all impacted by hospital performance on HCAHPS. Patient perceptions of care and interactions with nurses emerged as the most dominant theme found in the evidence demonstrating this as an important focus of the intervention to address the indicated problem.

Problem Statement

After a careful review of the literature and the organizational data, the problem statement has been refined as the following:

The current task-oriented nursing workflow dies bit allow for structured caring encounters which are in direct conflict with the communication needs of the medical patient population and can result in negative perceptions by the patient.

Expanded Literature Review for Best Practice

The analysis of the literature review on the issue of low HCAHPS scores indicates the need for interventions that are based on improved communication, caring encounter between the patient and nurse and increased patient family involvement in the plan of care. The intervention must also support listening, feeling cared for, and the establishment of trust. Another critical element to the success of the project is the ability to structure the intervention into the workflow process of the medical unit. History indicates previous interventions such as hourly rounding has not been successful due to lack of staff engagement. Key terms used in the literature review included nurse communication, evidenced based interventions, HCAHPS, patient centered care, and patient satisfaction.

Evidence Search Strategy

To begin the search strategy for evidence key questions were formulated to guide the literature review these questions included:

- What are the effects of bedside reporting on patient satisfaction?
- Does involving the patient in the bedside reporting help with communication?
- What is the impact of staff and physician engagement to bedside reporting?
- What is the nurse leader's role in the patient experience?
- What is the nurse leader's role in staff engagement?
- What improves HCAHPS and the patient experience for the medical patient population?
- Does nurse scripting improve the patient's perception of care, communication, and teamwork?
- How can transformational management assist with staff engagement, hardwiring, and change the culture and readiness for purposeful rounding?
- How can bedside reporting be individualized for improved success?
- What nursing theory best guides the development of improved communication and patient perception of hospital care?

Interventions That Impact Patient Satisfaction

In 2013 Press Ganey conducted an analysis of HCAHPS scores from 3,000 acute care hospitals in the United States. The results indicated that in addition to the *communication with nurses domains*, nursing had a significant impact on four other HCAHPS domains including:

- Responsiveness of staff
- Communication about medicines
- Pain management
- Overall rating of the hospital

Through the analysis of over 200 patient interviews, Berkowitz (2016) found that the nurse-patient relationship is a fundamental aspect of professional nursing care from the patient's perspective and had the most significant impact on the patient expressing a high level of patient satisfaction during a hospital stay. Important elements and prerequisites to the development of this relationship was the patient's level of trust. According to Berkowitz (2016), there were three key components important to the formation of trust which included the expression of genuine caring, demonstration of competent skills, and the communication of professional wisdom. Interventions implemented to increase patient satisfaction must address these key components of trust. Another important factor in patient satisfaction was the concept of caring. A literature review focused on caring behaviors of nursing indicated that caring by nurses can contribute to the satisfaction and well-being of patients, and when caring is not present dissatisfaction where the patient feels like an "object" can occur (Pajnkihar, Stiglic, & Vrbnjak, 2017). This finding points to the importance use of caring theory with best

practice interventions for patient satisfaction (Pajnkihar et al., 2017). Many best practices were recognized in the literature as having a positive impact on patient satisfaction including hourly rounding, acceptance introduction duration expectation and thank you (AIDET), leader rounding, and follow-up discharge phone calls, however one particular intervention became apparent that addressed all of the critical elements of the nurse/patient relationship, and the establishment of patient trust. This intervention was bedside shift report. The complex dynamic of the nurse/patient relationship and the need to incorporate the expression of a caring encounter with the patient requires an intervention structured to accomplish this. Bedside shift report emerged as the best intervention to meet this mandate. Further evidence to combining bedside shift report and caring science was illustrated in a comprehensive search of the literature from 2001-2013 which found that bedside reporting can become a venue to the expression of caring utilizing Watson's carative factors (Kusain, 2015).

Evidence for Bedside Report

One interesting fact that emerged from the evidence was how nursing attitudes were positively impacted by the implementation of bedside reporting along with nursing's perception of nursing accountability. Sand-Jecklin and Sherman, (2014) performed a quasi-experimental study on seven medical-surgical units across a large acute car health system that observed nursing attitudes pre and post implementation of a bedside report model. Approximately 70% of full time registered nurses were surveyed pre and post bedside report implementation utilizing a designed questionnaire to measure nursing attitudes. They found that nursing strongly felt bedside reporting fostered a culture change on their unit toward patient centered care. Vines, Dupler, Von Son, and

Guido, (2014) went further to define through a literature review how the management of the change process was an essential element to the implementation of bedside report. They looked at studies utilizing techniques involving both nursing interviews and survey questionnaires. A common trend emerged among the literature reviewed which listed nursing participation in the bedside report designed, involvement in the change process, and clear consistent communication as being top priorities among frontline staff indicating the importance of staff participation in the project design.

Nursing communication between shifts and peer building between shifts was another positive impact on nursing attitudes (Small & Fitzpatrick, 2017), however the effective handling of patient interruptions greatly influenced nurse's frustration and perception of the bedside report process. Utilizing a survey methodology Small and Fitzpatrick, (2017) measured nurse's perception of bedside reporting, and found evidence that the successful implementation and nursing engagement to bedside shift report was contingent upon how well the process was structured to provide for communication between nurses outside of the patient's rooms and the management of patient needs and interruptions during the bedside report. With the appropriate intervention structure, the evidence illustrated that bedside reporting changed practice but in addition bedside reporting also changed the overall nursing culture. The utilization of caring science use to establish a communication rapport with the patient was outlined in a study by Herbst, Friesen, and Speroni (2013). The study design restructured the bedside reporting process on five different med-surg units across a hospital system to include a scripted dialogue with the patient that also incorporated the patient plan for that shift. Nursing staff were trained on interventions to promote caring such as listening skills, sitting at the bedside

and prompting the patient to be involved in the bedside report. The study aim was to determine the impact of building the nurse/patient relationship through caring interventions. Results were obtained through a survey methodology that measured nurse's feelings and perceptions of improved communication, time-spent with the patient, and the overall quality of the time spent with the patient. Results indicated that interaction between the patient and nurse through bedside reporting changed the focus from performing task to true patient centered relationships (Herbst et al., 2013).

Nursing engagement and overall trust of the bedside reporting process was also positively influenced by the culture of safety established with the use of bedside reporting (Groves, Manges, & Scott-Cawiezell, 2016). Through a grounded theory methodology utilizing questionnaires, researchers looked at safety outcomes on a large med-surg unit related to fall prevention pre and post bedside report. Nursing staff were surveyed pre and post bedside report regarding their perceptions of patient safety related to nursing staff knowledge of patient fall risk and interventions obtained through shift report. Results indicated an increased level of safety and trust related to knowledge of this information post bed-side report implementation. Outcomes also indicated an overall decrease in fall rates on the unit by over 25%. The researchers felt this evidence validated the link between nursing communication and patient safety.

Impact on Patient Satisfaction and Change Management

At the center of the evidence for bedside reporting's positive impact on patient satisfaction is the building of the nurse-patient relationship. Kullberg, Sharp, Johansson, Brandberg, and Bergnmer, (2017) found that the patient's perception of nurse caring and listening increased by over 40% after the implantation of bedside reporting. In a cross-

sectional study comparing two nursing units, one utilizing bedside report, and one utilizing a nurse to nurse verbal report process, patient satisfaction scores on the unit utilizing a bedside report were increased by an average of 40%. The study examined both patient satisfaction score results and patient perception using a questionnaire incorporating communication and feelings of being cared for. The evidence also indicated the need for appropriate change management and engagement of staff to successfully implement and sustain bedside reporting.

Wakefield, Ragan, Brandt, and Tregnago, (2012) recommended at least a six-month period to allow for appropriate change management. Using a pilot methodology, the study aimed to examine whether the implementation and education design of the bedside report intervention had an impact on staff engagement and the sustainability of bedside shift report. Bedside report was rolled out to one nursing unit using a two-week in-service method, while the pilot unit received a six-month structured education and implementation utilizing change management interventions. Nursing and patient questionnaires along with patient satisfaction scores were utilized to measure nurse participation in bedside shift report and the level of patient satisfaction related to nurse communication. Results indicated increased patient satisfaction and bedside report sustainability on the pilot unit. Staff engagement is paramount to the success of the project as staff can be champions of bedside reporting or a significant barrier to success. (Anderson, Malone, Shanahan, & Manning, 2016). Strict sequential steps are necessary when implanting bedside reporting to allow for change management, and frontline staff input to address barriers, as well as time to individualize the process (AHRQ, 2013). The

literature review matrix for the best practice intervention of bedside reporting is presented in Table 3.

Table 3

Literature Review of Supportive Evidence for Evidence-Based Intervention for Problem

Citation	Research Design and Method	Conceptual Framework	Conclusions	Implications to Practice
(Sand-Jecklin & Sherman, 2014)	Quasi experimental pre-and post-implementation design on 7 medical-surgical units in a large university hospital	to quantify outcomes of a practice, change to a blended form of bedside nursing report	Several positive outcomes were resulted including time of shift report, nursing attitudes, and patient safety events	If properly implemented bedside reporting can result in Improved nursing perceptions related to shift report, nurse accountability, and safety of the unit
(Vines, Dupler, Von Son, & Guido, 2014)	Literature review	To evaluate bedside reporting to determine if evidence supports its use as an essential shift handover process	Evidence repeatedly supports the positive impact of Bedside reporting on HCAHPS and nursing satisfaction, but only if utilized with appropriate change management strategies	Supports patient-centered approach to nursing workflow
(Wakefield, Ragan, Brandt, & Tregnago, 2012)	Pilot study	To assess long-term results of the transition to bedside reporting on patient satisfaction, nurse satisfaction and sustainability,	For the unit where, bedside reporting was sustained there were significant sustained increases in six nurse specific patient satisfaction scores	The roll out of bedside reporting in the pilot unit was done over a six-month period, which allows for appropriate change management
(Anderson, Malone, Shanahan, & Manning, 2016)	Literature review	To review evidence for bedside clinical handover practices and the impact of appropriate implementation	It was identified that implementation structure played a key role in the sustainability of the bedside report handover process	Nursing engagement to the bedside handover process is tied to an appropriate structured implementation process
(Groves, Manges, & Scott-Cawiezell, 2016)	Grounded Theory Method	Describe how nurses can use nursing bedside shift report to keep patient safe	Describe how bedside nurses can use nursing bedside shift report to keep patient safe	Describe how bedside nurses can use nursing bedside shift report to keep patient safe

Citation	Research Design and Method	Conceptual Framework	Conclusions	Implications to Practice
(Kullberg, Sharp, Johansson, Brandberg, & Bergnmer, 2017)	Cross-sectional study	To compare a bedside reporting process to a verbal report process to see the impact of patient perceptions	The unit performing bedside reporting saw an increase of over 40% in patient satisfaction scores related to caring and listening	Bedside reporting positively impacts patient perceptions of nurse caring and listening
(Small & Fitzpatrick, 2017)	Survey methodology	Aim of the study was to measure nurse's perceptions of bedside reporting	Identified that patient safety, patient centered care, and operational workflow. Changes recommended were a time period for nurse to nurse communication outside of the patient room and decreased interruptions. BSR was more stressful due to having patient involvement	Nurse to nurse communication remains a priority for nursing staff. The structured process for bedside reporting must have minimal interruptions
(Herbst, Friesen, & Speroni, 2013)	Survey methodology	Described how a multihospital system utilized bedside reporting using a caring science perspective	By bringing shift report to the bedside, the nursing staff utilized ISHAPED (introduction, story, history, assessment, plan, error prevention, and dialogue as a reporting structure	By integrating caring into the bedside report, patient centered care became a cultural change for the nursing units engaged in this project. The article focused on the prior culture of task orientation of the workflow
("AHRQ," 2013)	Best practice implementation tool	AHRQ Nurses bedside shift report implementation handbook	Emphasized the steps for implementation of bedside reporting, and the evidenced based outcomes of patient safety and quality, patient experience, nursing satisfaction, and time management	Nursing will be greatest barrier; thus, implementation must include a team of frontline staff to develop the process

Note. Presents evidence to support the identified intervention of bedside report for the identified problem related to communication with nurses, the medical population and HCAHPS

Summary of the Evidence Bedside Reporting

As part of the literature review, one specific intervention emerged which addressed the critical needs of both the nursing staff and the patient population of the medical unit. This intervention was bedside reporting (McAllen, Stephens, Swanson-Biearman, Kerr, & Whiteman, 2018). The evidence also indicated that bedside reporting supports positive changes in the culture of safety, and peer relationships. Common themes within the evidence validated bedside reporting as an intervention to address patient satisfaction, nurse satisfaction, and patient safety. As the evidence shows, bedside reporting addresses all of the essential components for patient satisfaction, nurse satisfaction, and patient safety. However, another emerging theme was emphasized by AHRQ (2013) and Anderson et al., (2016) which emphasized the importance of the implementation structure and the staff engagement to bedside reporting. Herbst et al. (2013) indicated the connection between the concept of caring and the nursing culture which positively impacted the nursing workflow change away from being task-oriented. Essentially bedside reporting is a clinical expression of engaging patients and families as essential partners in the health care team (Herbst et al., 2013). Bedside reporting goes further than this definition by giving the patient the ability to be involved in their care and receive up to date information during their hospital experience. (AHRQ, 2013).

SECTION III

THEORETICAL FRAMEWORK

Watson's Theory of Human Caring (Watson, 2008) forms the theoretical underpinnings of the bedside report project. At the center of the bedside report process is the relationship between the nurse and patient. The link to patient satisfaction through bedside reporting is the impact on the communication with nurse's domain specifically through improved listening and explaining things in ways the patient can understand. To achieve this, a connection between the nurse and patient must be present through a caring moment (Kusain, 2015).

The Theory of Human Caring

The theory of caring science has evolved along with the nursing profession (Kusain, 2015). Through this evolution the merger of caring and science has formed the humanistic roots of nursing practice (Brewer & Watson, 2015). As patient satisfaction and the importance of the patient perception of *feeling cared for* takes center stage in modern health care, nursing practice applying caring concepts is utilizing caring as a way to establish the important connection between the nurse and the patient (Kusain, 2015). Although multiple theories of caring exist, Watson's Theory of Human Caring is unique in that the caritas processes guide behaviors necessary to build a caring relationship between the nurse and patient (Morrow, 2014).

Assumptions of the Theory of Human Caring

Assumptions of Watson's Theory of Human Caring include:

- Caring can be demonstrated and practiced effectively only through interpersonal relationships

- Human Caring and nursing have existed in every society where there has always been someone who has cared for another person
- The expression of caring can include the word that is spoken, the eye that sees leading to action, the gaze, the word, or a gesture framed in a voice or intonation. It is the expression of what is said, how it is said and can be welcoming, receiving, or affirming.
- The interpersonal process affects both the nurse and the patient (Jean Watson's Theory of Human Caring, 2017).

The expression of caring correlates directly with the bedside report process where intentionality, authentic presence, and spoken and unspoken communication between the patient and nurse influence the experience of a caring moment (Watson, 2008).

Carative Processes and Their Connection to Bedside Reporting

Watson has 10 carative factors that have been redefined into caritas processes for incorporation into nursing practice. The caritas processes of Watson's Theory of Human Caring reflect nursing behaviors which may help to achieve desired outcomes of the bedside report project that will positively impact the communication with nurse's domain as shown in Table 4.

Table 4

Theory of Human Caring Carative Processes Connection to Bedside Shift Report

Carative Process	Connection to Bedside Report
Practicing loving-kindness and equanimity within context of caring consciousness	Demonstrating respect of self and others Listening to others
Being authentically present and enabling and sustaining the deep belief system of self and one being cared for	Promoting intentional human connection with others Paying attention to others Utilizing appropriate eye contact and touch Calls other by the preferred name
Developing and sustaining a helping-trusting authentic caring relationship	Demonstrates sensitivity and openness to others Practices non-judgmental attitudes
Being present to, and supportive of the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared for	Actively listens Encourages reflection of feelings and experiences
Creatively using self and all ways of knowing as part of the caring processes: engaging in artistry of caring-healing practices	Uses self to create healing environment utilizing touch, voice, authentic presence eye contact, gesturing Encourages others to ask questions
Engaging in genuine teaching-learning experiences that attend to unity of being and meaning attempting to stay in another's frame of reference	Speaks calmly, quietly and respectively to others giving them full attention to the moment Seeks first to learn from others Provides information and tools to meet others needs Ask others what they know about their illness/health Helps others to formulate and give voice to questions and concerns
Creating healing environment at all levels (physical, non-physical, subtle environment of energy and consciousness), whereby wholeness, beauty, comfort, dignity, and peace are potentiated	Creating a healing environment, attending to light, noise, cleanliness, nutrition, safety, hand washing, comfort measures
Reverently and respectfully assisting with basic needs, with an intentional caring consciousness, administering "human care essentials", which potentiates alignment of mind-body-spirit, wholeness and unity of being in all aspects of care.	Make others as comfortable as possible Help others feel less worried Be responsiveness to others' family, significant others, and loved ones Involves family/significant others
Opening and attending to spiritual-mysterious, and unknown existential dimensions of one's own life-death-suffering: soul care for self, and the one being cared for; "allowing for a miracle"	Nurtures/support hope Shares and participates in human caring moments as appropriate

Note. Caritas Source (Watson, 2008).

Nursing Metaparadigm

The nursing metaparadigm of the Theory of Human Caring is presented below in Figure 5.

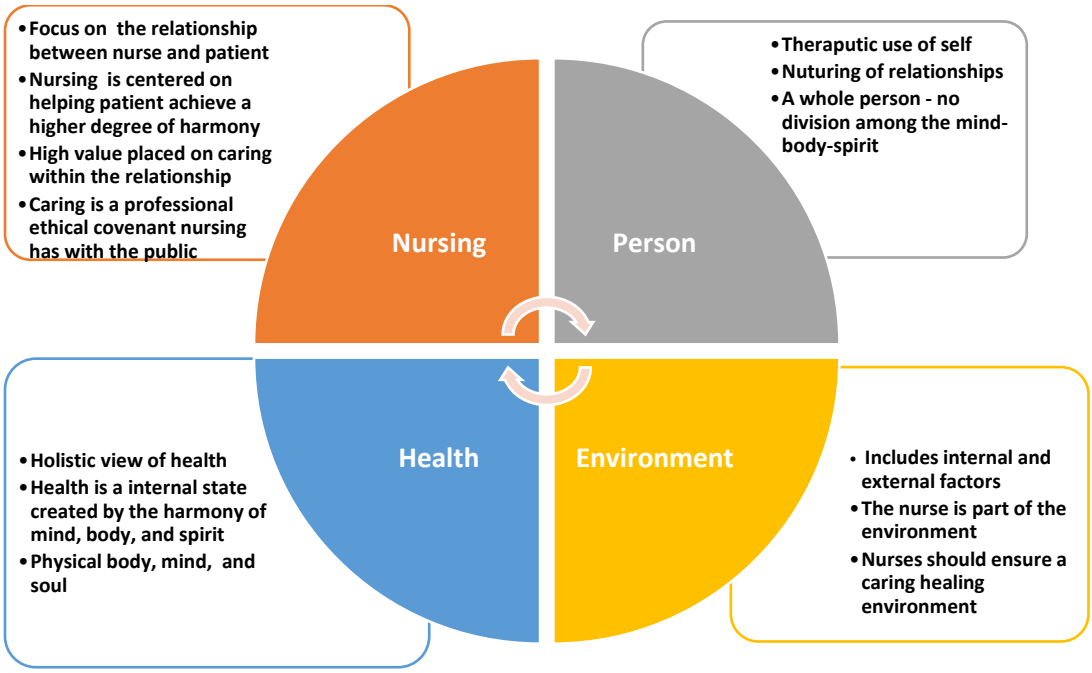

Figure 5. Watson's Theory of Human Caring Nursing Metaparadigm (Ozan, Okumus, & Lash, 2015).

Connection to the Bedside Report Project

Watson's theory utilizes caring as an interpersonal process that is present between two people and involves both the provider and the receiver of the care (Lukose, 2011). The relationship within the caring moment is reciprocal allowing each participant to give back what each is receiving. It is through this caring moment and authentic presence that the nurse is able to demonstrate to the patient during the bedside report process a positive perception of caring through verbal and nonverbal communication, eye contact, and active listening. In reciprocating the caring moment, the patient gives back

to the nurse a reaffirmation of purpose and value of the work (Lukose, 2011). The caring encounter between peers during the bedside report process reaffirms and establishes the connection through trust and respect. This strengthens the professional relationship and the common bond formed within the shared values and beliefs of the work (Lukose, 2011). The bedside report is an optimal time to share information with the patient, but also to improve patient outcomes as a result of the caring encounter. The interpersonal process of the caring moment can increase nursing powers of perception allowing for a more in-depth assessment creating an intuitive way of knowing to sense or perceive changes in the physical or mental state of the patient (Brewer & Watson, 2015). This speaks to the patient safety aspects of the bedside report process.

Watson feels that patients and nurses develop and sustain a caring relationship, perceive gratification of needs, and are able to express both positive and negative feelings as a result of the interpersonal relationship (Brewer & Watson, 2015). This aligns with the intent of the bedside report process as a caring encounter where questions, fears, concerns, and empathy can be expressed or experienced by all participating parties. This may further strengthen the caring relationship and perception of caring by the patient which may be key to increased patient satisfaction. Modern health care has evolved into a complex business model that is dependent on the patient experience. This experience involves staff interactions that must communicate caring. Evidence-based practices such as the bedside report will find success and sustainability when guided by theoretical frameworks that foster authentic relationship between caregivers and patients. The Theory of Human Caring brings to the bedside report process this deep human

connection that transforms the process from a task-oriented intervention to a caring encounter that satisfies expectations of both patients and staff.

SECTION IV

PROJECT MISSION AND GOALS

The mission and goals for the bedside report project evolve around increasing patient and nurse satisfaction through the building of the caring relationship. Patient centered care requires a human connection and interaction where those involved in the patient's care have a chance to both share information and listen to questions and needs (Herbst et al., 2013). Through this shared human connection, patients find both trust and satisfaction in their care, while nursing staff reconnect to the compassion, empathy and purpose that defines their chosen profession. The medical patient population has a distinct need for this human connection. As a result of chronic illnesses, medical patients are admitted into a health care system, while caregivers must meet the increased demands driven by organizational goals and patient acuity (Otani et al., 2012). This creates stressors where both patient and caregivers wall off the very emotions that encourage positive human interaction, focusing instead on just "surviving" or accomplishing the next task (Lukose, 2011).

Bedside Report Project Mission

The mission of the bedside report project is to enhance relationship building to improve communication between the nurse and the patient and to create a caring encounter through which the patient perception of *feeling cared for* is improved. The bedside report project mission is as follows:

- To promote patient satisfaction and safety through caring nurse/patient relationships and interactions between the nursing staff, patients and the individuals who contribute to the patient's support system.

- To facilitate a team approach to the development of a sustainable bedside reporting process that improves nurse/patient communication
- Promote nurse satisfaction in patient-centered care through authentic human connections and purposeful relationships

Bedside Report Project Goals

Utilizing information from the evidence search, the goals for the bedside report project are outlined as follows:

- Create a project team involving frontline staff, individualizing the bedside reporting project to the project setting and population.
- Team developed education interventions for staff bedside report training
- Use transformational management techniques to engage staff to bedside reporting
- Use Watson's Theory of Human Caring to engage staff in bedside reporting
- Promote patient centered care through the engagement of the patient and their support system in the plan of care
- Sustain bedside reporting through continued staff engagement.
- Measure the effects of the bedside report project implemented through caring science by
    - Using Watson's Caritas Patient Score tool
    - Staff Perceptions of Bedside Reporting survey for staff outcomes
    - Monthly review of HCAHPS scores

- Analyze patient/nurse survey responses using standard qualitative descriptive analysis methods to develop themes
- Increase the communication with nurse's domain of HCAHPS to the 80th percentile.
- Compare HCAHPS data monthly following implementation of theory guided bedside reporting on a monthly basis

The project goals will be incorporated into the timeline for the bedside report project to guide and measure progress of each defined phase.

SECTION V

NEEDS ASSESSMENT

PICOT Question

The overall purpose of the bedside report project is to determine if an individualized bedside shift report guided by caring science will result in an increase in the *communication with nurse's* domain as measured by results of HCAHPS scores in reviewing the defined problem and purpose of the bedside report project the PICOT (population, intervention, comparison, outcome, and time) question for the bedside report project is as follows:

In hospitalized patients on the medical unit, how does an individualized bedside shift report implemented through caring science, compared with a non-bedside shift report, impact the "communication with nurses" domain of the HCAHPS survey over a 6-month period?

The breakdown of the PICOT question and terms is outlined below in Table 5.

Table 5

PICOT Question Components

PICOT	Components
P (Population)	Hospitalized patients on medical unit
I (Intervention)	Bedside shift report performed by nursing staff utilizing caring science
C (Comparison)	Report methods of bedside shift report, and non-bedside shift report
O (Outcome)	Impact on communication with nurse's domain on HCAHPS survey of medical unit
T (Time)	6-month period

Note. Presents breakdown of PICOT components.

Desired Outcomes for the Bedside Report Project

The desired outcomes for the bedside report project are based on the categories of team, relationship, nurse, and patient. The desired outcomes will be incorporated into the evaluation and data collection plan to establish measurable levels of success for each outcome category and are presented below in Figure 6

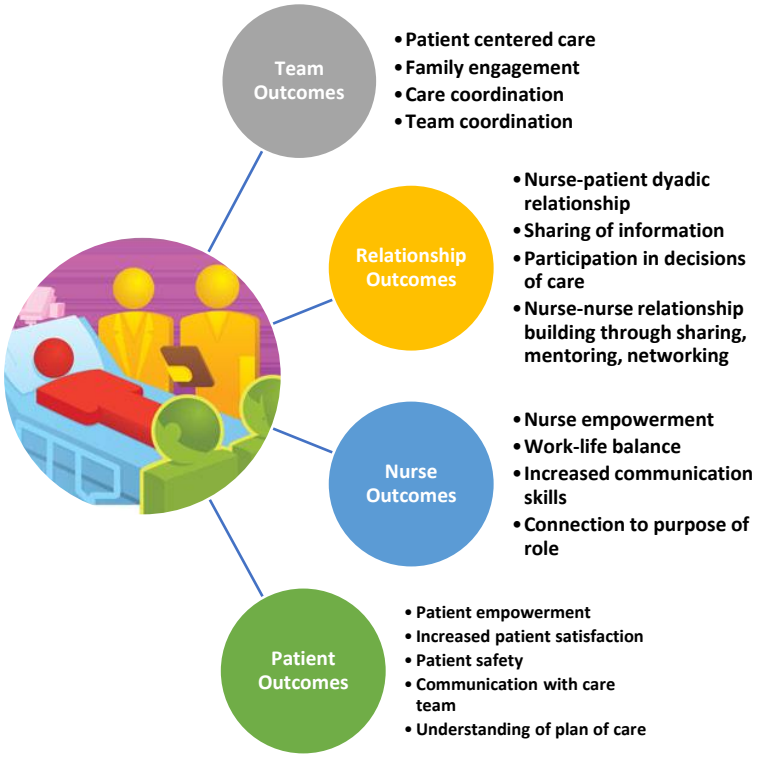

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Figure 6. Desired Outcomes in Each Category for the Bedside Report Project.

Organizational Readiness for Change Assessment and Gap Analysis

Managing change is essentially addressing staff's fears, uncertainty, and lack of trust. Changing a process is usually done with the intent to improve patient outcomes, thus it should be viewed by staff as a positive intervention. However, staff's reaction to change may be unpredictable and irrational. If not managed correctly, change can result in failure or ineffectiveness of a new process (Frieson, Foote, Frith, & Wagner, 2012). An organizational readiness for change assessment is a survey conducted by administrative staff that requires addressing key questions prior to implementing a new process. These questions include:

- Does the hospital promote a culture of safety?
- Why is change needed?
- Does staff understand why change is needed?
- Is there a sense of urgency for change?
- Is there leadership support for the change?
- Who will take ownership of the process?
- What kind of resources will be needed? (AHRQ, 2013)

Environmental Challenges and Readiness

Transition to a bedside reporting process can present both challenges and barriers. However, low HCAHPS scores are a significant problem for hospitals that must be addressed for optimal patient outcomes, safety, and financial viability. Due to the magnitude and importance of the project, implementation of a bedside shift report requires a multidisciplinary approach that entails simultaneous changes to workflow and communication. Thus, this scale of organizational change can be difficult to achieve

(Thomas, Seivert, & Joyner, 2016). An assessment of the organization's readiness for change must be completed to ensure successful implementation of the project and identify barriers and facilitators to the desired practice change (AHRQ, 2013). An assessment of the organizational readiness for change was performed using key questions from the AHRQ Strategy 3 nurse bedside shift report guideline with the following results shown in Table 6.

Table 6

Organizational Readiness Assessment

Readiness Question	Assessment of Organization	Identified Barrier/Facilitator
Does the organization promote a culture of safety?	Yes, the hospital culture values promote a culture of safety	Facilitator for change
Do organizational members understand why change is needed?	No, the bedside reporting process is not performed. Shift report on the medical unit is performed verbally in the nursing lounge with no patient involvement. Staff lacks education as to the importance and need for change	Barrier to change
Is there a sense of urgency about the change?	No, education is needed as to the sense of urgency related to HCAHPS scores	Barrier to change
Is there leadership support for this effort	Yes, administration has verbalized support for the bedside report project	Facilitator for change
Who will take ownership of this effort?	The bedside shift report project implementation team has been identified, and initial planning steps has begun	Facilitator for change
What kind of resources are needed?	Yes, a preliminary list of resources has been developed which includes labor cost, and time commitment. Initial approval has been obtained from administration but updates will be necessary	Both a barrier and facilitator for change
What will be needed for project implementation and sustainability?	No, identification requires actions and work redesign from the implementation team but planning steps has begun	Both a barrier and facilitator for change

Note. Readiness assessment performed at acute care hospital setting.

Gap Analysis

Currently, a readiness assessment has never been performed at the organization, and current shift hand off does not utilize bedside reporting. The gap analysis for the practice change recommendations for bedside reporting is outlined in Table 7.

Table 7

Gap Analysis of the Practice Change Recommendations for Bedside Reporting

Selected Intervention	Existing Policy or Practice? Yes/No	Policy or Practice being followed? Yes/No
Bedside shift report	No	No

Note. A readiness assessment has never been performed at the organization, and current shift hand off does not utilize bedside reporting.

SWOT Analysis

A SWOT (strength, weaknesses, opportunities, and threats) analysis is an important examination tool of an organization or department's internal strengths, and weaknesses, its opportunities for growth and improvement and the threats the external environment presents to the process of success and improvements (Helms & Nixon, 2010). The SWOT Analysis Matrix for the bedside report project (see Appendix A) demonstrates much positive internal strength including a high commitment to teamwork and the high employee satisfaction scores. Leadership commitment to both employee and patient satisfaction is also important to implementing and sustaining change. These positive factors can be utilized to lessen the impact of the indicated weaknesses of a task-oriented workflow and low staff morale on the unit. The utilization of the participatory model and caring science to implement bedside reporting will be another important factor to address the indicated internal weaknesses. The SWOT Analysis Matrix demonstrates and clarifies areas to incorporate into the strategic plan for the bedside report project.

Barriers/Facilitators/Strategies

Barriers identified from the organizational readiness assessment include the following:

- Awareness and knowledge: Evidence shows that healthcare professionals are often unaware and unfamiliar with the latest evidenced based best practices (Grant, Colello, & Riehle, 2010).
- Motivation: This is key to engage staff to change. External and internal factors can drive motivation levels and change (McMurray, Chaboyer, Wallis, & Fetherston, 2010).
- Acceptance and beliefs: Acceptance and beliefs will influence engagement and staff perceptions of the practice change's ability to impact patient outcomes (McMurray et al., 2010).
- Skill sets: New skill sets requiring training are necessary to make the practice change happen.
- Practicalities: These include cost, staff turnover, and resource constraints

Strategies to Address Barriers and Facilitators

The bedside report implementation team will drive the development and application of strategies to address the identified barriers. These strategies will include staff education regarding the "why behind the what" of the bedside report project. Strategies will include updating staff on current HCAHPS scores, and statistics through department meetings, bulletin boards, and staff rounding through frontline and leadership representatives of the implementation team. Additional staff education will be necessary to teach new skills sets for the bedside reporting project. This will be achieved through

scheduled staff in-servicing, practice, and competency sessions. Staff acceptance and beliefs will be addressed through the bedside implementation team members who will be "champions" for the bedside reporting project. The frontline team members will provide peer guidance and role modeling for the staff, while the leadership team members will use transformational leadership practices which evidence shows promotes staff engagement to the project (Grant et al., 2010). Connecting staff to the theoretical framework of the project and re-energizing the purpose and reward of their work is paramount to the success and sustainability of the bedside reporting project. Cost and resources can be addressed through proactive tracking and reporting to the administration team. A complete cost analysis for the project will be presented to administration with an outlined budget. Facilitators for the project including the support of leadership, culture of safety, and the implementation team members will be utilized to promote and market the bedside reporting project to the staff and key stakeholders through consistent communication. As the project progresses, staff will be updated on HCAHPS scores, staff, patient, and family feedback to show progress of the project goals.

Population/Community Impacted

The population impacted by the bedside reporting project includes all patients admitted to observation or inpatient status the medical unit. This population also includes all nursing staff working on the unit, patient family members, caregivers, and guardians. Variations of the patient population will include factors such as marital status, diagnosis, payment source, gender, and age. Variations of the nursing staff population will include gender, age, job type, years of experience, and education level.

Project Team and Stakeholders

The successful implementation of the bedside report project requires "ownership" by project team members and key stakeholders. Without these key individuals, an organization's readiness for change will be impacted Readiness to change requires both capability and motivation. Project team members and key stakeholders bring the knowledge, influence, and power for ideas, and necessary resources to implement the desired practice change (McMurray et al., 2010). Identifying these individuals allows the project to be designed to address the needs and interest of all project members and key stakeholders (Martin et al., 2016). What is compelling and relevant to each team member and stakeholder will be different based on their role in the organization. Addressing these diverse needs will allow for less barriers and resistance during implementation of the project, more abstract thinking, and analysis such as benefit vs cost.

Project Team Members

The team for the bedside report project must be interdisciplinary and involve members who have a particular interest, ownership and expertise that will be a positive influence on the development of the intervention (McMurray et al., 2010).

Criteria for forming an effective project team includes

- A strong connection to hospital leadership
- Members who possesses the necessary expertise
- A clearly defined goal and purpose for the team
- Access to resources to accomplish the team goals (McMurray et al., 2010)

Members for the bedside report project team are listed in Figure 7

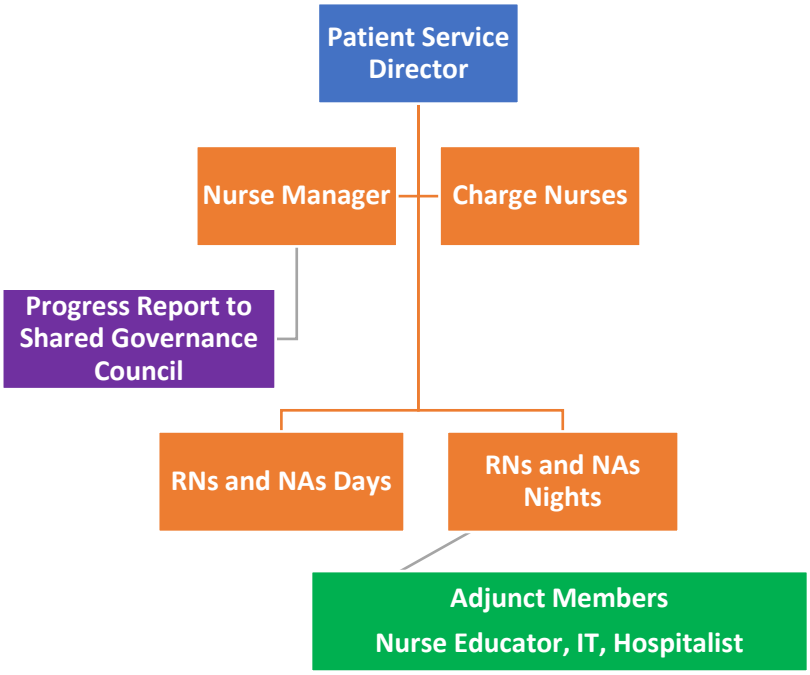

Figure 7. Bedside Report Project Team Members.

Reason for Membership

The bedside report project team members must represent individuals who have the knowledge and ownership to be engaged in designing, implementing, and sustaining a successful fall prevention program. The patient service representative for the medical unit was selected as team facilitator, and assisted in organizing, analyzing, and presenting HCAHPS data. The nurse manager helped the team prioritize improvement goals, reported team activity to organizational leaders, and set accountability standards for charge nurses, and staff. The nurse manager gave regular updates to the shared governance council of the unit to assist with staff engagement and change in the workflow of the unit. The charge nurses brought important to bring specific department management information to the team such as staffing structure, model of care delivery,

patient population information, and staff accountability. Frontline staff members including nurses, and nursing assistants from both day and night shift contributed expertise regarding actual workflow, practice gaps, and become champions for the bedside report project's implementation, and staff engagement success. Regular team membership numbers were around 11 individuals with frontline staff representation consisting of two RNs days, two RNs nights, two NAs days, and two NAs nights. Adjunct members such as information technology, nurse educators, and the hospitalist liaison for the medical unit were included in team meeting as needed.

Key Stakeholders of Project

Engaging stakeholders is important as stakeholders can have a positive or negative influence on the project's success. Key information important to collect and analyze from key stakeholders include:

- Current HCAHPS scores
- Shift reporting practices currently in practice
- Current workflow practices on the medical unit
- Expectations of service
- Awareness or involvement in patient satisfaction
- Interest and reaction towards implementing a bedside shift report process
- Potential for cooperation, threat, level of support, and influence (McMurray et al., 2010)

The consulting of key stakeholders can be done in a number of ways such as focus groups, interviews, written or electronic communication. Several key stakeholders also serve on the project team. It is important to consult the key stakeholders at regular

intervals throughout the project as levels of interest and cooperation can change over time (McMurray et al., 2010) Internal stakeholders directly impacted by the bedside reporting project include:

- Nursing/Nursing leaders/CNO – Directly responsible for fall prediction and prevention, and outcomes
- Clinical support staff (PT, pharmacy) – Expertise related area
- Organizational leaders (CEO, CFO, Board of Trustees) – Business and financial viability interest related to marketing, liability, reimbursement, and reputation of organization
- Hospitalist – Directs patient care and treatment, also responsible for outcomes
- Education director – Assist in stakeholder's education regarding fall prevention project interventions
- Patient service – Directly responsible for measuring and handling the patient experience, and service recovery

External stakeholders indirectly impacted by the fall prevention project include:

- Patients/families – Expectation of safety in hospital, and impacted by short and long-term effects or harm from fall
- Community physicians – Personal patients served by hospitals
- Vendors – Potential equipment or product needs identified by the bedside report project team.
- Community care providers (home health, long-term care) – Patients served by hospital, and care provided after hospitalization

Summary of Intervention Plan

Interventions for the bedside report project will be multidisciplinary and will require collaboration with the project team members. The interventions are based on recommended best practices outlined in the AHRQ Strategy 3 Nurse Bedside Shift Report Guideline and Toolkit. Interventions were planned in six distinct phases as outlined below. Each project phase had a proposed timeline and completion date.

Phase One

- Cost analysis and budget development for project
- Presentation of overall project, goals, and cost analysis to administrative team members
- Formation of bedside report project team
- Organizational readiness for change assessment

Phase Two

- Project team analysis and action steps for readiness assessment results
- Project team analysis and action steps of current shift reporting process
- Project team development of interventions to assist staff with change and engagement processes
- Interventions to engage staff to caring encounters, caring relationships, and workflow change
- Formation of pre-and post-project nurse and patient surveys

Phase Three

- Project team development of bedside report process intervention including workflow analysis, logistics of incorporating bedside shift report, staff education, and training plan
- Development of tools
    - Patient/family education handout
    - Bedside report patient information tool
    - Staff education and training tools
    - Monitoring tool for management team
- Project marketing plan
- Evaluation plan development
- Staff interventions to promote caring relationship based on theoretical framework (ongoing)

Phase Four

- Staff education and training on bedside shift report
- Charge nurse education on accountability processes, tools, and evaluation of bedside shift report

Phase Five

- Implementation of bedside shift report on medical unit
- Implementation of evaluation plan
- Implementation of post-project implementation data collection plan

Phase Six

- Analysis of data collection
- Assessment of project results, expectations, goal achievement
- Post-project nurse and patient surveys

Cost Benefit Analysis of Project

A cost benefit analysis is important to evaluate the cost and feasibility of a proposed change or intervention (Newhouse, 2010). The cost benefit analysis for the bedside report project is based on current adverse cost, projected project cost, projected cost savings, and cost avoidance savings. The adverse cost observed due to the current reporting system include staff overtime, communication and patient adverse events, nursing staff turnover, patient dissatisfaction resulting in decreased market share and decreased revenue. Projected project cost consists of both expected training and implementation labor cost, and materials. The projected cost savings and benefits for the bedside report project include cost savings related to decreased staff overtime, and staff turnover, increased revenue related to expanding market share from improved patient satisfaction, and cost avoidance related to decreased communication failures, errors, or patient adverse events. The cost benefit analysis for the bedside report project is presented below in Figure 8.

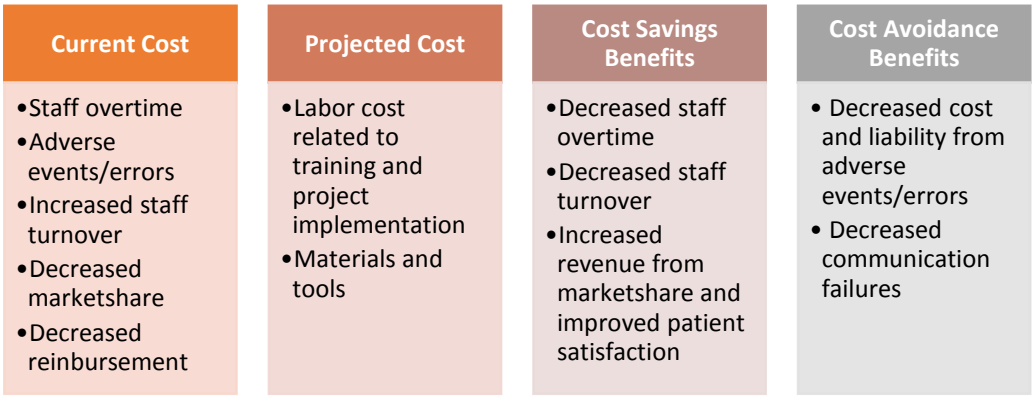

Figure 8. Cost Benefit Analysis for Bedside Report Project.

SECTION VI

EVALUATION PLANNING

Project Proposal, Implementation Plan, Evaluation Plan

The bedside report project was guided by the project timeline included in Appendices B-D. The project phases were incorporated into the timeline which indicates desired milestone dates and goals.

Participatory Model for Project

This evidence-based project is unique in that it integrates a participatory action model, using a project team to develop education and procedures specific for the unit culture. The participatory action model embodies the very essence of caring science by utilizing the thoughts, feelings, perceptions, beliefs, and interactions between human beings to best design a project to establish an intervention which promotes an authentic caring encounter and relationship between the patient and nursing (Hills & Carroll, 2016). Harrison and Graham (2012) found that the use of the participatory model positively influenced the facilitation of research on evidence-based practice. They conducted a study involving best-practice protocols for a wound clinic at a large university health system. Utilizing a collaborative approach with the participatory model, they involved frontline staff on the use of the evidence-based protocols, and staff participation. They found that collaborative research used to achieve evidence-based practice implementation resulted in maximum results at the practice level. Forums held with staff and researchers indicated that front line managers and staff provided a reality check in terms of feasibility, realistic targets, and what was possible. This was essential to the effective collection of the needed data. The participatory model also assists in the

change management process. Nielsen and Randall (2012) illustrated that the participation of employees in the development and implementation of an intervention may help to ensure that changes take place. In a longitudinal study, a link was established between sustainability of changes to work-flow processes, employee satisfaction with change and a participatory employee committee guiding the new process change. Pre and post employee surveys indicated a greater than 90% employee engagement to the new process. Within nursing management, the use of the participatory model has received further validation with its association to the shared governance process. French-Bravo and Crow (2015) performed a literature review to determine prerequisites for nursing buy-in and engagement to evidence-based practice changes. They reviewed research illustrating successes and failures with new practice interventions, they found that the common factors associated with the successful implementation included the use of shared governance, staff collaboration and input on the new practices. The participatory action requires human interaction that encourages a collaborative team approach to the identified problem. Patient service by its very nature requires a unified approach which establishes both communication and trust between both staff and patients. The participatory action model encourages this interaction which will be required for the success and sustainability of the project.

Bedside Report Team

The bedside report team consisted of a total of 11 members including charge nurses, nurses, nursing assistants and the project leader. Members were elected to the team by the medical unit staff. Bedside report team membership was presented in Figure 6. The team began meetings in October 2017 meeting bi-weekly up until the

implementation date in early April 2018. Working sessions of the bedside report team include the following:

- Development of caring initiatives and staff engagement activities based on caring science
- Presentation for kickoff of bedside report initiatives for staff meeting
- Identification of potential barriers
- Solutions to identified barriers
- Patient education brochure design
- Bedside report patient preparation process
- Bedside report process design into workflow
- Bedside report content
- Bedside report tool design
- Patient and staff survey process and distribution method
- Staff education process, content, and outline for bedside report
- Participation in staff education process including role play
- Process outline for implementation day
- Process for bedside report monitoring and staff accountability
- Process for staff feedback, ongoing sustainability
- Design and planning for staff celebrations on bedside reporting

Implementation Work Plan

Privacy and choice was addressed for each patient in the implementation plan as follows:

- Upon admission the patient and/or family/caregivers were educated about the bed side report process utilizing the bedside report educational brochure.
- The patient was asked permission to perform the bed side report at which time the patient could decline to participate in the bed side report process. This information was included in the nurse and nursing assistant hand off process
- Prior to the bedside report time, the patient was reminded of the upcoming bedside report on staff rounding, and reaffirm patient wish to participate
- Upon entering the patient's room, the staff introduced themselves and the bed side report process

Post-implementation, the bedside report team met monthly to discuss identified barriers and adjustments necessary to improve the bedside report workflow. The participatory model was a key element in that it allowed the bedside report process to be designed based on frontline staff members knowledge of the actual unit workflow. The early identification of potential barriers by the bedside report team also allowed for the team members to participate and lead staff engagement initiatives based on caring science. This prevented staff resistance from emerging as an actual barrier. The bedside report team membership remained consistent throughout the project. Team members openly discussed caring science and embraced the ability to improve staff morale and patient satisfaction. One helpful team exercise was taking the caritas processes and

connecting them to bedside reporting see Table 4 on page 33. Team members openly verbalized to the project leader and the charge nurses the positivity they felt in making a difference and having input into the bedside report intervention.

The content of the bedside shift report included the overall patient diagnosis and condition over the past shift, the patient plan of care for the next shift, updates related to test, procedures etc., and any patient questions or concerns. The patient's room marker board was utilized as well to inform the patient of the names of their care team members, and any important information that will be focused on for the upcoming shift.

Staff engagement and preparation for the bedside report project was guided utilizing Watson's Theory of Human Caring. Staff interventions involving caring meditation, listening, and connection to purpose was utilized during project leader staff rounding at least twice weekly, daily staff huddles, staff weekly updates and at quarterly staff meetings. The bedside report process was designed by the team to encompass shift handoff information such as overall patient diagnosis and condition over the past shift, the patient plan of care for the next shift, updates related to tests, procedures etc., any patient questions or concerns, as well as interventions guided by Watson's Theory of Human Caring based on language, listening, and physical presence to create a caring encounter between the patient, and nurses. Staff education on the bedside report process was completed and involved participation of the bedside report project team.

Educational sessions were incorporated into staff's schedules. Staff were scheduled to attend at 30-minute intervals during which they participated in role play and practiced the bedside report process. A competency check-off sheet was completed by charge nurses on each staff member. As part of the bedside report process, the patient and

family were prepared and educated on the bedside report process upon admission to the medical unit utilizing the bedside report educational brochure and a patient information letter which outlines the patient's rights regarding the bedside report process, and the benefits of bedside reporting. Shift report for patients who declined to participate in the bedside report process took place in a confidential and secure area away from the patient's room. The bedside report took place twice daily at 0645 and 1845. The dayshift and nightshift nurses and nursing assistants performed the shift report at the patient's bedside encouraging and incorporating the patient and family in a patient-centered approach to care. The patient information marker boards inside of the patient room were used to list patient goals and plan for the day as well as any patient or family questions requiring follow- up during the shift.

Project Evaluation Plan

This project was a quality improvement project implementing the best practice use of bedside report. Patient outcomes were measured using the HCAHPS survey and the Watson Caritas Patient Score tool (WCPS). The five items of the WCPS emerged from Watson's Caring Theory (2008) as universals of caring phenomenon and foundational indicators of human caring, demonstrating face validity. The items empirically assessed the patient's subjective experience of receiving caring; the items refer to such indicators as loving kindness, trust, dignity, healing environment, and honoring of beliefs and values (Brewer & Watson, 2015). The scale demonstrates satisfactory reliability through internal consistency with a Cronbach's alpha .90. Construct validity has been evaluated using exploratory factor analysis with principal components using varimax rotation, which resulted in a single factor explaining 76% of

the variance. Factor loadings by item ranged from 0.766 to 0.906 (Brewer & Watson, 2015). Staff outcomes were measured utilizing the Staff Perception of Bedside Report Scale, created by the DNP student. Face validity was established in collaboration with the faculty advisor and practice partner. There is no reliability data currently.

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data was obtained and descriptively analyzed monthly with a focus on the communication with nurses' domain questions that include: *How often did nurses treat you with courtesy and respect? How often did nurses listen carefully to you? How often did nurses explain things in a way you could understand?* Analysis of HCAHPS data began two months before and continued 4 months after the implementation date of the bedside report project.

The Watson Caritas Patient Score (WCPS) tool was used to measure patient perception. Patients on the medical unit were rounded on at least once prior to discharge by the project leader or her designee. Upon agreeing to participate, patients were given the survey and asked to put the completed survey in a sealed envelope. The survey was collected at the time of the patient's discharge by the discharging nurse who then placed the sealed envelope in a collection folder at the medical unit desk. The surveys were collected at routine intervals by the project leader or her designee. Patients who were unable to complete the survey independently were verbally asked the questions by the project leader or her designee if they choose to participate. Results of the Watson Caritas Patient score tool was analyzed monthly.

The Staff Perception of Bedside Report Scale was given to all staff on the medical unit by the project leader 30 days post bedside report project implementation. The

bedside report team determined the most effective distribution method for the Staff Perception of Bedside Report scale to nursing staff. The distribution method was a manual distribution to each staff member at a staff meeting. The staff were instructed to return the completed survey within a week to a designated secure collection box in the staff lounge. Results of patient outcomes were analyzed descriptively and utilized by the project leader, bedside report team, and Wilkes Medical Unit staff to measure project outcomes, and the need for adjustments or updates to project interventions. Results were posted monthly on the bedside report bulletin board located in the staff lounge, included in staff updates and meetings.

SECTION VII

PROJECT IMPLEMENTATION

Project Outcomes

The impact of a bedside shift report implemented through caring science was measured by the "communication with nurses' domain of the HCAHPS survey. Staff education was completed in phase four over a two-month period. The bedside report implementation and data analysis was completed in phases five and six over a 10-week period.

Project Team Building

Team building and cohesion was a crucial element to the success of the bedside report project, and its sustainability. The bedside report team identified staff resistance as an early identified barrier. Overall staff morale was negatively impacted by consistent feedback based on low HCAHPS scores. Communication and relationships were strained or non-existent, especially between shifts. This, along with the task-oriented workflow of the unit, had resulted in the lack of nurse to patient relationships aligning feelings of stress and frustration with patient satisfaction, as well as staff "walling off" feelings of enjoyment and pleasure with their work as caregivers. Patient encounters became robotic and task driven. Project leader rounding pre-project implementation resulted in staff verbalizing these feelings of frustration describing their work as "just wanting to get through the day" and viewing any new intervention as "just another thing to do".

The bedside report team identified key interventions guided by caring science to assist staff to connect back to the love and enjoyment of their work, such as a nurse or nursing assistant letting go of the past and looking forward to meaningful relationships

and reconnecting to the special purpose and fulfillment in their work. Interventions designed by the bedside report team and the connection to caring science are outlined in Figure 9.

Figure 9. Caring Science Interventions Designed through Staff Collaboration

Staff Education Implementation

The bedside report team determined the staff training and bedside report implementation plan. Through the participatory model, staff training dates and contents were developed for the bedside report structure, contents, and workflow process. A bedside report tool was designed by the bedside report team in conjunction with staff from information technology. The tool could be automatically printed by staff from the electronic medical record containing all of the essential patient information elements for the bedside report. Staff education was completed involving the participation of the bedside report team. The educational program was designed by the bedside report team over a period of two months. The bedside report educational sessions were held in the outpatient area in vacant patient rooms so staff could practice using an actual room environment. The sessions were taught by the project leader and all of the bedside report team members. Sessions were held every Tuesday and Thursday during the month of January. There were two four-hour block sessions scheduled each day.

Two staff members of the same discipline (nurse or nursing assistant) were scheduled in one-hour intervals to walk through patient room stations. At each patient room station, bedside report team members would role play as patients and family members. Each staff member was given a patient case study to practice bedside reporting. Utilizing lecture and role play, staff were trained on the bedside report communication tool, and process. Caring Science involving the caring encounter, authentic presence, human connections and relationships between patients, and peers was central to the design of the bedside report process and staff education. Staff practiced with bedside report team members, and then with the fellow staff member. Staff were

checked off using the staff education tool. Staff were instructed by the project leader they could attend as many practice sessions as they wished during the month of January. Eight staff members requested to attend another educational session, approximately 60 staff members including nurses and nursing assistants participated in the staff training resulting in 100% staff education participation rates. Staff verbalized satisfaction with the design and outcome of staff educational sessions during project leader rounding post bedside report implementation.

Bedside Report Tool Development

The bedside report team collaborated with information technology to create a tool to be utilized with the bedside shift report. The bedside report team obtained input from other frontline staff members who verbalized important factors which included:

- The request for the tool to be able to be printed off the computer instead of staff having to manually write patient information on a form
- Specific information to be included on the tool including allergies, activity, primary diagnosis, diet, lines, tubes, drains, code status and a section so the nurse could free text any additional needed information.
- Minimal writing was requested to not distract from listening and communicating with the patient and family

All of these factors were included in the development of the tool. Information technology staff spent time with nurses and nursing assistants on the medical unit. The report was built to include the requested information. The bedside shift report tool was printed each shift by secretarial staff for the oncoming shift. The tool was then given to the nurse and nursing assistant assigned to each patient. Bedside report team members,

charge nurses, and the project leader rounded on staff to assess the use and effectiveness of the bedside shift report tool. The bedside shift report tool was a product of nursing and information technology collaboration. The tool allowed the nursing staff to focus on the caring encounter without the distraction of having to write large amounts of patient information on a form. The ease of printing the report ~~off~~ positively impacted the workflow at change of shift.

Bedside Report Implementation

The implementation plan was contingent on activities that ensured continuous support, monitoring, and communication for sustainability and engagement of the direct care staff. The bedside report team planned kickoff celebrations and staff recognition activities throughout the project development and implementation which included:

- Bedside stories – Staff were given personal notebooks and pens to write a short story describing a special patient encounter that made a difference to them
- Caring meditations utilizing caring quotes and prayers at the beginning of each shift and at staff meetings. The hospital chaplain performed a "blessing of the hands" monthly for each staff member
- Each staff member received a Nightingale lamp pin to wear on their badge as a symbol of the medical healing team
- A big kickoff staff meeting celebration was given where the staff received their Nightingale lamp pin, and were served a special dinner
- A caring weekly newsletter containing caring science-based quotes was sent to all staff outlining the bedside report teams progress

- Celebration events were held monthly to recognize staff birthdays. A birthday card signed by all staff was given to staff members having birthdays
- Recognition and reward prizes such as candy, pens, snacks etc. along with a thank you card was given by the project leader, charge nurses, or bedside report team members in recognition of identified encounters between staff or patients and staff that represented caring science
- A bedside report breakfast was held on the project roll-out day for all staff. The lounge was decorated with signs, balloons etc.
- A celebration of success bedside report dinner was held in honor of the staff at the May staff meeting. Bedside report team members and staff were honored by the project leader and hospital administration

The project leader, charge nurses for the medical unit, and members of the bedside report team piloted the patient rounding prior to the project implementation date to ensure patient education and understanding of the bedside report process. During the project go-live, continuous support, monitoring, and rounding was performed by the project leader and charge nurses throughout the key components of the bedside report process including the 6:30am/pm briefing huddle and bedside report process which began daily at 6:45am/pm. Caring science literacies of listening, connecting, and relationship building were a focus of the leadership team during staff rounding. Throughout the project implementation period staff were asked for feedback concerning staff input on ideas or changes to the bedside report process.

Bedside Report Process

Upon admission the patient and/or family/caregivers were educated about the bed side report process by the admitting nurse utilizing the bedside report educational brochure. The patient was asked permission to perform the bed side report at which time the patient could decline to participate in the bed side report process. At around 5am and 5pm staff rounded on patients to remind them of the upcoming bedside report and address any needs such as toileting, fluids etc. At 6:30am and 6:30pm a briefing huddle was performed in the staff lounge which lasted approximately 5-15 minutes. Upon arrival to the unit, staff received their patient assignments and entered the briefing huddle. During the briefing huddle safety information, such as falls and restraints, was shared. Report for any patients who declined bedside reporting was given to assigned staff members following the briefing huddle.

Bedside report began immediately after the briefing huddle with staff from each shift assigned to the patient entering the patient's rooms to report at the bedside. Upon entering the patient's room staff introduced themselves and "managed up" their fellow staff members by emphasizing excellent care to the patient. The content of the bedside shift report included the overall patient diagnosis and condition over the past shift, the patient plan of care for the next shift, updates related to tests and procedures, and any patient questions or concerns. Patient questions or concerns were addressed by the oncoming nurse. The patient's room marker board was utilized as well to inform the patient of the names of their care team members, and any important information that was to be focused on for the upcoming shift by the nurse or physician. At the end of the bedside report staff thanked the patient and any family member attending the bedside

report. For each shift, bedside report began by 6:45 am or 6:45pm and was completed by approximately by 7:05am or 7:05pm. The total report averaged around 15 to 20 minutes. Delays in the report completion were based on patient condition changes or new patient arrivals at shift change. Adjustments for these were designed and implemented by the bedside report team and project leader. Nurses then reported any questions or concerns to be addressed by the physician to the hospitalist or surgeon assigned to the patient for that shift.

Identified vs Actual Barriers

During the planning of the bedside report interventions, the bedside report team identified anticipated barriers to the successful implementation of bedside shift report the identified barriers were ranked based on likelihood of occurrence and disruption level. Intervention strategies for each barrier utilizing Watson's Theory of Human Caring were encompassed in the bedside report intervention design and implementation plan. Figure 10 demonstrates the barriers identified pre-implementation, intervention strategies for the identified barriers, and the actual barriers identified post implementation.

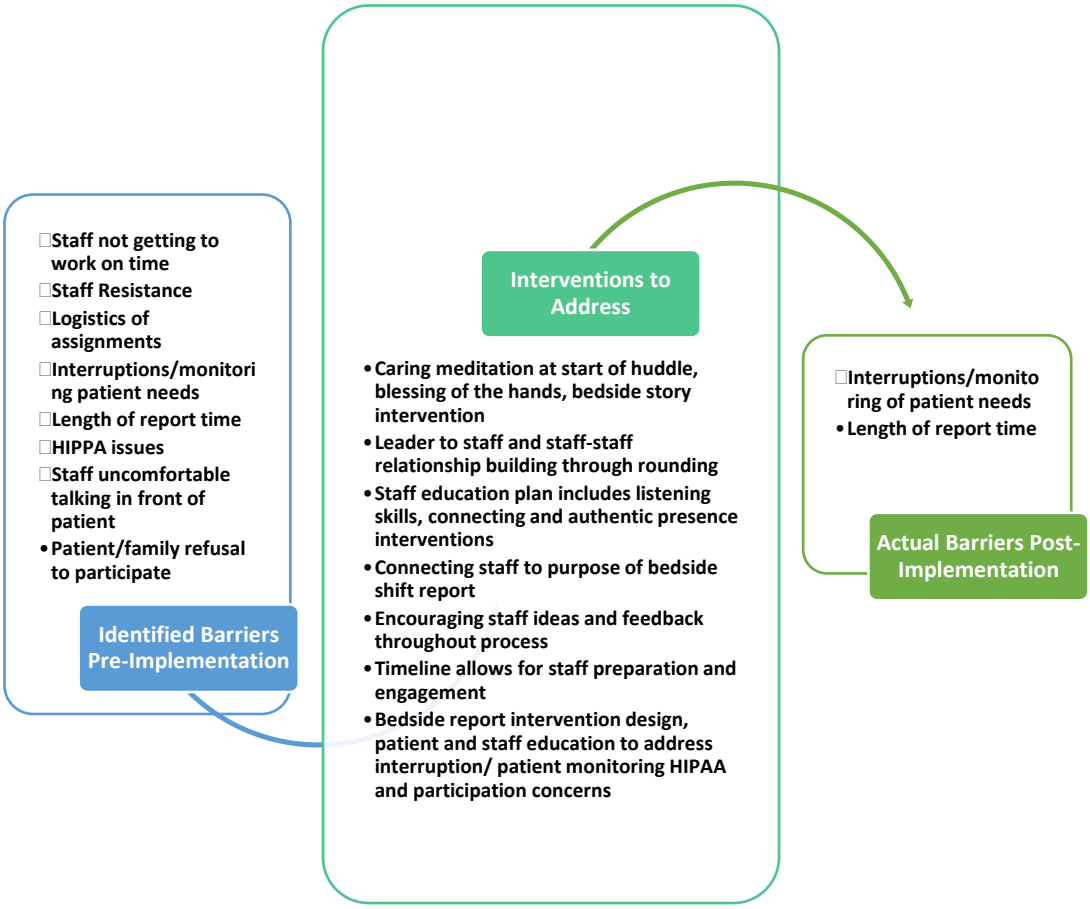

Figure 10. Identified vs Actual Barriers. Pre-implementation Identified Barriers, Interventions to Address, and Actual Post-implementation Barriers.

Adjustments to Project

The bedside report team met monthly post implementation to address any needed adjustments to the bedside report process. The actual barriers identified post-implementation of bedside shift report were related to interruptions due to new patients arriving and patient call lights during the change of shift. Only 2% of the patient admitted to the medical unit during the project implementation declined to participate in bedside reporting. The bedside report team and management staff established processes to handle the identified interruptions. For any patient admitted to the unit at 6am, 6pm or

later, the patient was settled and greeted by nursing staff, vitals were obtained and stat orders addressed. The patient was oriented to the room and updated during the bedside shift report. The patient admission history and assessment were completed by the next shift. The medical unit desk staff and charge nurse handled any patient calls occurring during the bedside shift report. These adjustments resulted in fewer interruptions during the bedside report process on each shift.

SECTION VIII

PROJECT RESULTS

Outcomes for Patient and Staff Surveys

Data outcomes from the Watson Caritas Patient Score instrument and the Staff Perception of Bedside Report Scale are presented below in Tables 8 and 9. One hundred-three paper and pencil instruments were collected from patients during the survey period. The instruments were collected at the time of discharge and placed in an envelope for the project leader. A few patients required assistance by the discharging nurse to mark patient responses on the instrument. Overall, patients perceived that staff always met their needs with caring kindness over 90% of the time. The question concerning valuing personal beliefs and faith scored lower than the others. The Watson Caritas Patient Score results are presented in Table 8.

Table 8

Watson Caritas Patient Score Outcomes

Watson Caritas Question Category	Score range 1(Never) – 7 (Always) Results in percentage
Delivering care with loving kindness	1 - 0 2 - 0 3 - 0 4 - 0 5 – 1% 6 – 2% 7 – 97%
Meeting basic human needs with dignity	1 - 0 2 - 0 3 - 0 4 – 3% 5 – 2% 6 – 2% 7 – 93%
Helping and trusting relationships	1 - 0 2 - 0 3 - 0 4 – 1% 5 – 3% 6 – 6% 7 - 90%
Create a caring environment	1 - 0 2 - 0 3 - 0 4 - 0 5 – 1% 6 – 8% 7 – 91%
Value personal beliefs and faith	1 - 0 2 - 0 3 – 2% 4 – 3% 5 – 2% 6 – 8% 7 – 85%

Note. Data results based on 103 patient survey returns during project implementation period.

Sixty surveys were collected from staff over a two-week period 30 days post project implementation. Surveys were collected in a collection box placed in the staff lounge. Overall staff perceived bedside report improved patient safety, patient satisfaction, and overall communication between patients and staff. The question concerning staff feeling competent to perform bedside report scored lower than the others. The Staff Perception of Bedside Report results are presented Table 9. Survey results indicated staff perceived the bedside report process created a caring encounter between nursing and improved communication between staff and patients.

Table 9

Staff Perception of Bedside Report Outcomes

Staff Perception of Bedside Report Question Category	Score range 1(Strongly Agree) – 5 (Strongly Disagree) Results in percentage
I feel bedside report improves patient safety	1 - 0 2 - 0 3 - 0 4 - 0 5 – 100%
I feel bedside report improves patient satisfaction	1 - 0 2 - 0 3 - 0 4 – 2% 5 - 98%
I feel bedside report improves communication between staff and patients	1 - 0 2 - 0 3 - 0 4 - 0 5 – 100%
I feel the current bedside report process creates a caring encounter between nursing and patients	1 - 0 2 - 0 3 - 0 4 - 0 5 – 100%
I feel competent with the bedside report process	1 - 0 2 - 0 3 - 0 4 - 7% 5 - 93%
I participate in bedside reporting during my shift handoff	1 - 0 2 - 0 3 - 0 4 - 0 5 –100%

Note. Data results based on 60 staff survey returns during project implementation period.

Data Outcomes HCAHPS Survey

Project outcomes based on data from the HCAHPS survey *Communication with Nurses* domain is presented in Figures 11, 12 and 13. Data from the *Communication with Nurses* domain in HCAHPS indicates overall positive increase from 70.9% to 89.0% of patient indicating the top score of "always" ("Press Ganey," 2018). March data was collected pre-implementation to the bedside report intervention. May data was collected two months post bedside report implementation. This is presented in Figure 11.

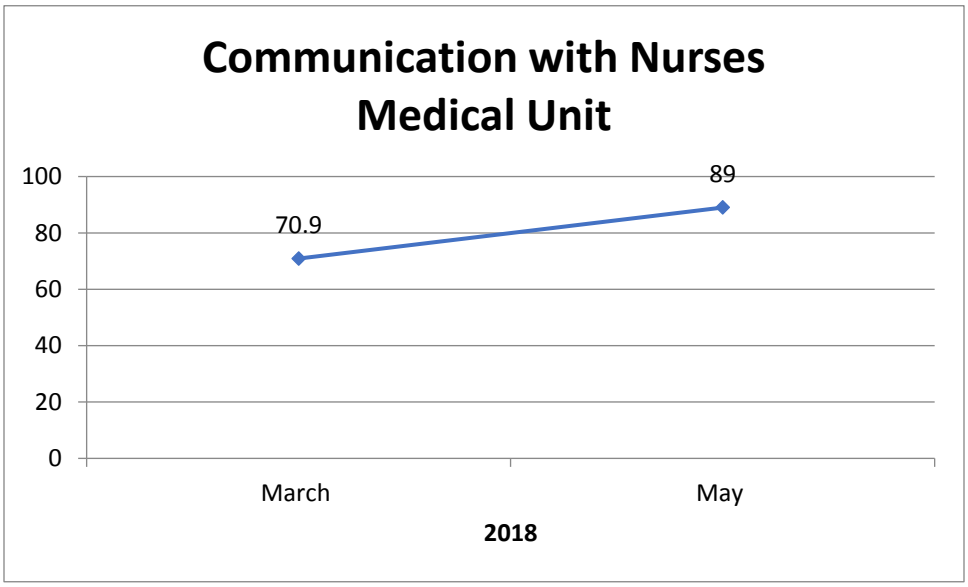

Figure 11. Communication with Nurses. Project Outcomes from HCAHPS "Communication with Nurses" Domain

Data from the key question within the *Communication with Nurses* Domain in HCAHPS *Nurses listened carefully to you* indicates an increase from 68.3% to 85% of patients indicating the top score of "always" (Press Ganey, 2018). March data was collected pre-implementation to the bedside report intervention. May data was collected two months post bedside report implementation. This is presented in Figure 12.

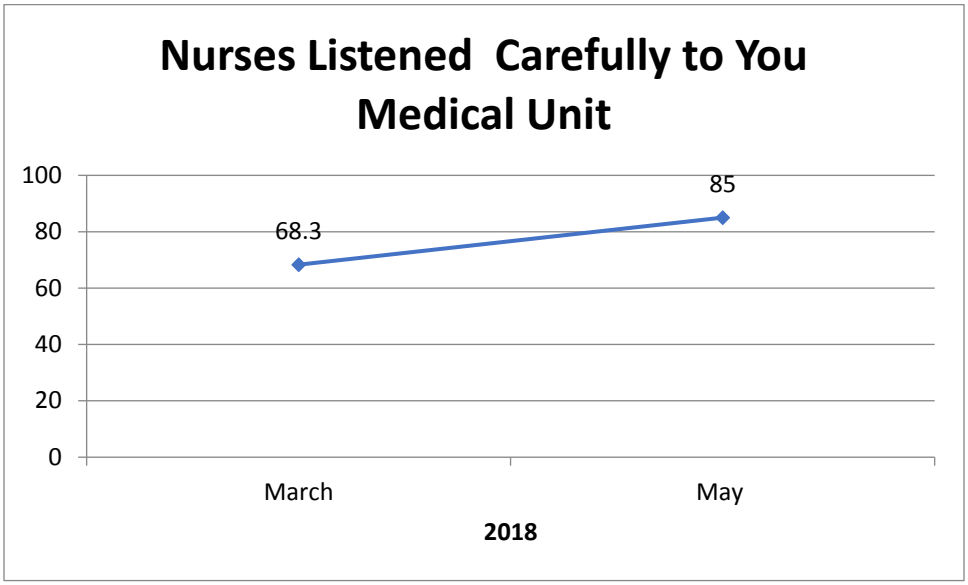

Figure 12. Nurses Listened Carefully. Project Outcomes from "nurses listened carefully to you" Question from HCAHPS "Communication with Nurses" Domain.

Data from the key question within the *Communication with Nurses* domain in HCAHPS *Nurses explained things in ways you understand* indicates an increase from 63.9% to 81.3% of patients indicating the top score of "always" (Press Ganey, 2018). March data was collected pre-implementation to the bedside report intervention. May data was collected two months post bedside report implementation. This is presented in Figure 13.

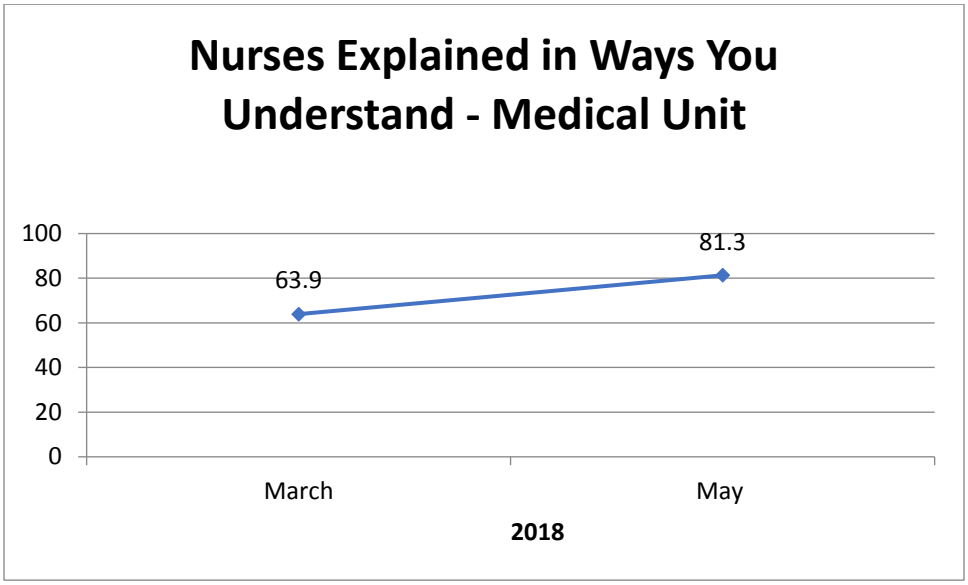

Figure 13. Nurses Explained Things. Project Outcomes from "Nurses explained things in ways you understand" Question from HCAHPS "Communication with Nurses" Domain.

SECTION IX

INTERPRETATION OF FINDINGS

The project outcomes show a positive impact on both patient satisfaction and staff engagement to the bedside shift report. The practice change intervention initiated in the bedside report project was a bedside shift report designed using the participatory model guided by Watson's Theory of Human Caring (2008). The project goals were focused on a team approach to the development of the bedside report intervention and process, with a goal to promote both patient and nurse satisfaction. The project results demonstrate evidence of patient satisfaction and patients feeling c*ared for*. Staff results suggested evidence of staff engagement to the bedside report intervention and an improved relationship to their patient.

Summary Review of Problem

The medical unit consistently performed lower in the *communication with nurses* HCAHPS domain than other nursing department in the organizations demonstrated by the score comparisons of the medical and surgical unit. Between 2015 and 2017 the overall *communication with nurses* score in the HCAHPS domain ranged between 74-79%. The medical unit consistently performed lower in the *communications with nurses* domain, specifically the questions, *nurses listened carefully to you* and *nurses explained things in ways you understand*. The nursing workflow of the medical unit was focused on completion of tasks, instead of patient interaction, caring, and communication. HCAHPS scores for the medical unit reflected a conflict between patient needs and nursing workflow. HCAHPS scores of the medical unit had a negative impact on patient outcomes, staff satisfaction, and organizational reimbursement. This quality

improvement project to implement best practice bedside report guided by Watson's Theory of Human Caring produced key findings which demonstrate positive outcomes for patients, staff, and the organization.

Key Findings

Outcomes of the bedside report project corresponded with the literature review of supportive evidence. Actual findings substantiated that proper implementation of bedside report resulted in a positive staff perception of bedside report. Bedside reporting also appeared to have a positive impact on HCAHPS scores. The structure of the implementation, designed in a participatory model with staff nurses, was also found to be extremely important to the success of bedside reporting project. Positive nursing engagement through culture change guided by caring science was also substantiated in the project outcomes. These results with corresponding literature are presented in Table 10.

Table 10

Expected vs Actual Findings Based on Evidence

Expected Finding	Actual Finding	Evidence Supported (Yes/No)
Proper Implementation of bedside reporting results in positive nursing perceptions (Sand-Jecklin & Sherman, 2014)	The Staff Perception of Bedside Report Survey indicated an overall positive perception of bedside reporting as indicated in Table 9.	Yes
Bedside reporting supports patient-centered care, a positive impact on HCAHPS, and nurse satisfaction if utilized with change management strategies (Vines et al., 2014)	HCAHPS results indicated a positive increase in the *communication with nurses* domain demonstrated in Figure 10.	Yes
Nursing engagement to the bedside report process is tied to an appropriate structured implementation and the implementation structure played a key role in the sustainability of bedside reporting (Anderson et al., 2016)	Project outcomes indicate a successful implementation and positive effects from the utilization of the participatory model	Yes
Integrating caring into bedside reporting results in a cultural change for the nursing unit (Herbst et al., 2013)	A structured timeline, and Watson's Theory of Human Caring utilized for planning and implementation	
Nursing will be the greatest barrier, implementation must include frontline staff ("AHRQ," 2013	Identified vs actual barriers indicate positive nursing engagement	
Bedside reporting positively impacts patient perceptions of nurse caring and listening (Kullberg et al., 2017)	*The nurses listen carefully to you* of the *communication with nurses* domain indicated a positive increase demonstrated in Figure 11. Watson Caritas Patient Survey indicated positive results indicated in Table 8.	Yes
The structured process for bedside reporting must have minimal interruptions (Small & Fitzpatrick, 2017)	Interruptions was identified as the top actual barrier which required adjustments to the bedside project	Yes

Note. Actual findings based on project outcomes collected over project timeline and 10-week project implementation period.

Key findings of the bedside report project include:

1. Bedside report has a positive impact on the *communication with nurses* domain" of HCAHPS as evidenced by the project outcomes.
2. Patients on the medical unit have an overall feeling of being *cared for* as evidenced by the Watson Caritas Patient Score outcomes.
3. Watson's Theory of Human Caring guided the implementation of bedside reporting which had a positive impact on staff perception, staff engagement, the likelihood of sustainability of the project, and both peer to peer, and staff to patient relationships as evidenced by project outcomes.
4. Managing interruptions and patient needs during the bedside report is important for successful implementation and workflow as evidenced by identified vs actual barriers and project outcomes.
5. The use of the participatory model and a structured timeline allowed for staff collaboration, staff preparation, successful implementation, staff engagement, and plans for sustainability.

Sustainability

The bedside report project focused on a practice change implemented over a six-month timeline which incorporated caring science interventions, the participatory model through a bedside report team, and staff education. Outcomes indicate successful staff engagement, but for continued sustainability, nursing and organizational leadership must continue to monitor performance, establish relationships guided by caring science principles, and share success stories of improved patient satisfaction with staff. Leader rounding on both staff and patients will reinforce the core mission and goals of the

bedside report project. The bedside report project is a culture change of patient centered care through caring science.

Implications for Practice/Future Recommendations

Future recommendations for nursing research include conducting further studies in the use of caring science to implement evidenced based practices such as bedside shift report. HCAHPS and patient satisfaction has placed a great emphasis on nursing communication and building nurse/patient relationships. Although patients have a generalized trust in the overall nursing profession, evidence has shown that patients equate satisfaction to feeling *cared for* (Ashish et al., 2008). While evidence shows the positive impact of bedside shift report, further exploration of connecting bedside shift report to caring science is needed to further establish this as a catalyst to successful implementation, staff engagement, and sustainability of evidenced-based practice interventions.

The lack of staff engagement is a reoccurring theme in current research on bedside reporting. Evidence indicates disengagement as one of the top reasons organizations fail to successfully implement bedside reporting into nursing practice (McAllen et al., 2018). Research on how to overcome these barriers is crucial for bedside reporting to be supported as an evidence-based, collaborative and patient-centered intervention in acute care organizations. Additional research is also needed to establish bedside reporting impact on other patient satisfaction elements such as communication with physicians. The communication with physician domain of HCAHPS increased from 61% to 90% of patients scoring “always” during the project implementation time period. The reason for this increase could be improved

communication of patient needs and questions during the bedside report process. This information was given to the physician and written on the white boards in the patient's room by nursing to be addressed during the physician/patient interaction. This was not a component of the bedside report project, but outcomes have established a need for further research.

The project outcomes also indicated that Watson's Theory of Human Caring had a positive impact through the establishment of relationships, staff engagement, and project sustainability. These results indicate both a practice recommendation and the need for further research on clinical practice outcomes guided by caring science. The implications for practice recommendations are presented in Table 11.

Table 11

Implications for Practice Recommendations

Key Finding	Domain Impacted	Recommendations
Bedside report has a positive impact on the *communication with nurses domain* of HCAHPS as evidenced by project outcomes	Practice, Policy, & Research	Adapt as standard of practice in the organization Incorporate into policy and practice for shift handoffs Continuation of data review to strengthen and validate project findings Adapt policies to assist nursing leaders in accountability standards for bedside reporting Additional research regarding impact on additional HCAHPS domains such as "communication with physicians"
Patients on the medical unit has an overall feeling of being "cared for" as evidenced by the Watson Caritas Patient Survey outcomes Utilizing caring science through Watson's Theory of Human Caring to implement bedside reporting had a positive impact on staff perception, staff engagement, and the likelihood of sustainability of the project as evidenced by project outcomes and identified vs actual barriers.	Practice, Education & Research	Adapt bedside reporting as a component of the nursing culture of patient-centered care Include bedside reporting in new nursing education and orientation Utilize caring science as part of the staff preparation and education for implementation of interventions such as bedside report Conduct further research on the use of caring science to implement evidenced-based nursing practice interventions
Managing interruptions and patient needs during the bedside report is important for successful implementation and workflow as evidenced by identified vs actual barriers and project outcomes	Practice & Education	As part of the implementation planning develop processes to address interruptions and patient needs during the bedside report and incorporate into staff education
Results suggest that the use of the participatory model and a structured timeline allowing for staff preparation improves success of implementation and staff engagement as evidenced by project outcomes	Practice & Research	Utilize structured accommodating timelines for implementation of interventions such as bedside reporting Use participatory model including frontline staff to plan and implement new practice interventions such as bedside report Conduct further research on the use of the participatory model to implement evidenced-based nursing practice

Note. Project outcomes collected over project timeline and 10-week project implementation period.

Lessons Learned

Lessons learned from the bedside report project include:

- Staff preparation and education incorporating caring science and the participatory model were keys to the early success of the project. The accommodation of these elements into the project timeline was essential.
- A cohesive leadership team who role model and communicate with patients and staff incorporating rounding into the daily routine is important.
- Continuous feedback loops and outcome measurement is necessary to make needed adjustments to the project and sustain staff motivation.
- The participatory model and bedside reporting both create blurred boundaries between nurses and between nurses and patients, which encourages interventions and solutions designed and delivered *with* individuals, rather than *to* them.
- Incorporating caring science has a positive impact on reducing barriers related to staff engagement.
- Caring science encouraged relationship building between peers and between patients and staff, fostering open communication, trust, empowerment, and an overall acceptance of a cultural change for the medical unit.

Limitations

The project was limited to a single patient care unit in a rural hospital setting within a large health system. Results were based on data collected over a 10-week

period. Sustaining the best practice through continuous nurse relationship building and patient partnership will strengthen positive outcomes as a result of bedside reporting.

Plans for Dissemination

The project intervention and data collection will continue to provide further evidence for the project results. Further expansion to additional inpatient units in the organization and hospital system are planned. A presentation of the project and results will be made to organizational and system leadership. Publication of the project will be sought in nursing leadership publications, and with publications and organizations associated with caring science. Additional presentations related to the utilization of caring science to implement evidence-based practice will also be explored at national organizations such as the American Organization of Nurse Executives (AONE).

Conclusions

The bedside report project outcomes indicate a positive impact on scores in the c*ommunication with nurses* domain of the HCAHPS survey. The bedside report was a significant change in both practice and culture for the medical unit; however, project results suggest that positive outcomes in patient satisfaction, nurse engagement, and the patient/nurse relationship can be attained through the implementation of bedside shift report. Outcomes suggest a positive link between staff engagement and the use of caring science to implement the intervention of bedside shift report. Staff interview comments included a consistent theme of closeness, understanding, empathy, having a sense of purpose, improved communication between staff, and reduced feelings of frustration. Survey results indicated staff perceived the bedside report process created a caring encounter between nursing and improved communication between staff and patients.

Patient survey results indicated an overall feeling of being *cared for*. Another suggestion of the positive influence of caring science on the bedside report project was that the identified barriers of staff resistance and reporting to work on time were not observed during the 10-week implementation period.

The utilization of Watson's Theory of Human Caring fostered relationships which not only created engagement to the project but also changed the overall purpose of the bedside report from a "shift" report to a "caring encounter" through a person-centered focus that is about the patient and not just the staff. The project outcomes also suggested that caring science and a participatory model is key to successfully engaging staff to implement evidence-based practice interventions. The human connection improves staff team building and collaboration and is necessary to partner with patients to meet expectations of quality care, provided through trust and respect as a human being. Bedside reporting guided by the Theory of Human Caring (Watson, 2008) achieved this mandate and demonstrated a successful blend of theory and practice.

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Appendix A

SWOT Analysis Matrix

Strengths	Weaknesses
Largest patient population in the hospital Largest number of FTEs of any nursing unit Unit based shared governance council Recent move to a newly remodeled unit High teamwork scores on employee satisfaction survey High commitment scores on employee satisfaction survey High commitment of nurse manager to improve scores High productivity level of nursing staff Recent decrease of nurse to patient ratios to 6:1 Strong management team	Staff are "task" oriented and reactive instead of proactive Staff fear of reporting in front of patient and family Staff fear of HIPPA violation Staff lack of engagement to previous interventions such as hourly rounding Staff morale related to HCAHPS scores High number of staff interruptions during report Current assignment system inconsistent between shifts No structured tool utilized for report
Opportunities	**Threats**
Large patient services network for resourcing Formation of project team for implementing of purposeful rounding Access to Press Ganey reports to track trends and changes in HCAHPS scores Access to staff training material and tools to educate staff on HCAHPS and proven interventions Support of the education director of bedside report project Increased reimbursements and revenue related to HCAHPS and marketing Support of system CNE of bedside reporting AHRQ Strategy 3 Bedside Shift Report Tool available for reference	Recent transition to new hospital system and computer system Reimbursement penalties related to HCAHPS Short amount of time given by CEO to improve scores Weak physician engagement to HCAHPS Unknown timeframe of support for labor cost, training, planning, and implementation of project

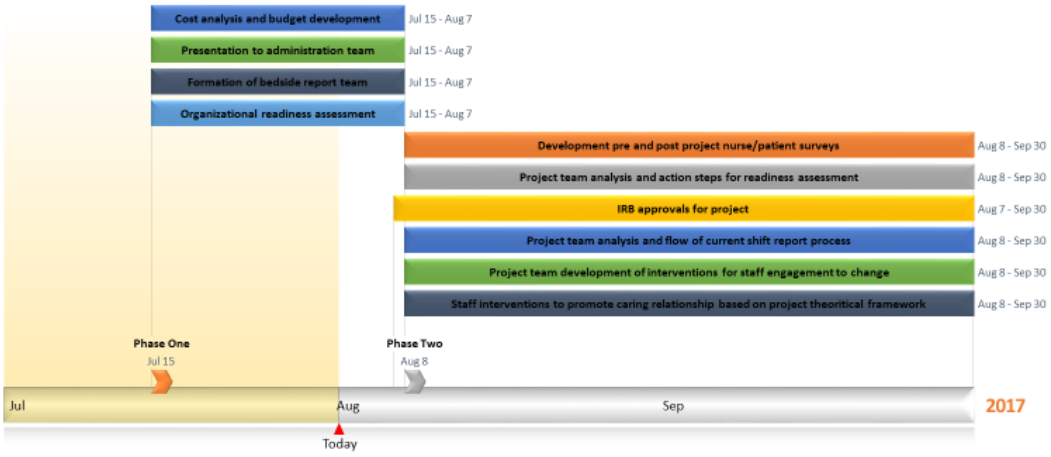
Appendix B

Timeline Phases 1 & 2

Timeline: 07/15/2017 - 09/30/2017

Milestone(s)	
Date	**Description**
07/15/2017	Phase One
08/08/2017	Phase Two

Task(s)			
Duration (days)	**Start Date**	**End Date**	**Description**
16	07/15/2017	08/07/2017	Cost analysis and budget development
16	07/15/2017	08/07/2017	Presentation to administration team
16	07/15/2017	08/07/2017	Formation of bedside report team
16	07/15/2017	08/07/2017	Organizational readiness assessment
39	08/08/2017	09/30/2017	Development pre and post project nurse/patient surveys
39	08/08/2017	09/30/2017	Project team analysis and action steps for readiness assessment
40	08/07/2017	09/30/2017	IRB approvals for project
39	08/08/2017	09/30/2017	Project team analysis and flow of current shift report process
39	08/08/2017	09/30/2017	Project team development of interventions for staff engagement to change
39	08/08/2017	09/30/2017	Staff interventions to promote caring relationship based on project theoritical framework



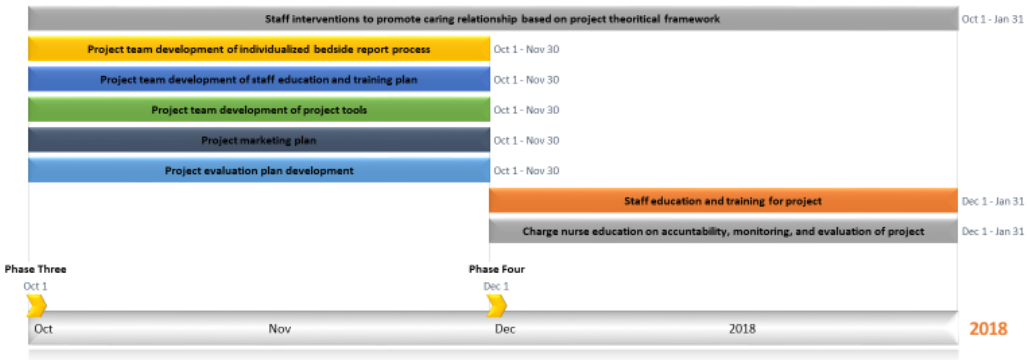
Appendix C

Timeline Phases 3 & 4

Timeline: 10/01/2017 - 01/31/2018

Milestone(s)	
Date	**Description**
10/01/2017	Phase Three
12/01/2017	Phase Four

Task(s)			
Duration (days)	**Start Date**	**End Date**	**Description**
88	10/01/2017	01/31/2018	Staff interventions to promote caring relationship based on project theoritical framework
44	10/01/2017	11/30/2017	Project team development of individualized bedside report process
44	10/01/2017	11/30/2017	Project team development of staff education and training plan
44	10/01/2017	11/30/2017	Project team development of project tools
44	10/01/2017	11/30/2017	Project marketing plan
44	10/01/2017	11/30/2017	Project evaluation plan development
44	12/01/2017	01/31/2018	Staff education and training for project
44	12/01/2017	01/31/2018	Charge nurse education on accuntability, monitoring, and evaluation of project



Appendix D

Timeline Phases 5 & 6

Timeline: 02/01/2018 - 06/29/2018

Milestone(s)	
Date	**Description**
02/05/2018	Phase Five
05/02/2018	Phase Six

Task(s)			
Duration (days)	**Start Date**	**End Date**	**Description**
64	02/01/2018	05/01/2018	Staff interventions to promote caring relationship based on project theoritical framework
62	02/05/2018	05/01/2018	Implementation of bedside report project intervention
62	02/05/2018	05/01/2018	Implementation of evaluation and data collection plan
43	05/02/2018	06/29/2018	Analysis of data collection
43	05/02/2018	06/29/2018	Assessment of project results, expectations, goal achievement