

**Date:** August 12, 2013

**Title:** Increasing Patient Satisfaction by Moving Nursing Shift Report to the Bedside

**Clinical Question:**

- |   |                      |  |
|---|----------------------|--|
| P | (Population/Problem) | Among patients and families                                  |
| I | (Intervention)       | does implementation of bedside nurse to nurse shift report   |
| C | (Comparison)         | versus a non-bedside nurse to nurse shift report             |
| O | (Outcome)            | increase patient/family satisfaction during hospitalization? |

**Target Population for the Recommendation:**

Inclusion criteria: All hospitalized patients; if under age of 18, with caregiver present.

Exclusion criteria: Patients/Parents electing not to participate.

**Recommendation:**

It is recommended that nurses perform bedside shift to shift report, to increase patient/family satisfaction (Maxson, Derby, Wroblewski, & Foss, 2012 [4a]; Radtke, 2013 [4a]; Sand-Jecklin, Sherman, 2013 [4a]; Tidwell et al., 2011 [4a]; Thomas, Donohue-Porter, 2012 [4b]).

**Discussion/Synthesis of Evidence related to the recommendation:**

The grade for the body of evidence was moderate. Five of the six studies used a descriptive design (Maxson, Derby, Wroblewski, & Foss, 2012 [4a]; Radtke, 2013 [4a]; Sand-Jecklin, Sherman, 2013 [4a]; Tidwell et al., 2011 [4a]; Thomas, Donohue-Porter, 2012 [4b]), with the other being a systematic review of literature (Riesenburg, Leitzsch, & Cunningham, 2010 [1b]).

The systematic review of literature examined 55 studies in order to determine best practice related to nursing handoffs and concluded that communication was the biggest barrier to an effective handoff (Riesenburg, Leitzsch, & Cunningham, 2010 [1b]). Additionally, standardized strategies and inclusion of the patient and family in rounds were noted as a key factor in effective handoffs but no linkage to patient satisfaction was discussed (Riesenburg, Leitzsch, & Cunningham, 2010 [1b]).

Descriptive studies were conducted on med-surgical units with sample sizes ranging between 25 and 232 patients family members (Maxson, Derby, Wroblewski, & Foss, 2012 [4a]; Radtke, 2013 [4a]; Sand-Jecklin, Sherman, 2013 [4a]; Tidwell et al., 2011 [4a]; Thomas, Donohue-Porter, 2012 [4b]). Studies used Likert surveys for their outcome measures. Pre-implementation and post implementation surveys were given to patient's family members as well as nursing staff in regards to satisfaction. Survey questions elicited feedback regarding patient/family perception around communication and teamwork, safety, being a part of their plan of care, and satisfaction with the care provided (Maxson, Derby, Wroblewski, & Foss, 2012 [4a]; Radtke, 2013 [4a]; Sand-Jecklin, Sherman, 2013 [4a]; Tidwell et al., 2011 [4a]; Thomas, Donohue-Porter, 2012 [4b]). All studies reported an increase in patient/family satisfaction post implementation of bedside nurse to nurse reporting; although no statistical significance was found, the results are clinically significant (Maxson, Derby, Wroblewski, & Foss, 2012 [4a]; Radtke, 2013 [4a]; Sand-Jecklin, Sherman, 2013 [4a]; Tidwell et al., 2011 [4a]; Thomas, Donohue-Porter, 2012 [4b]). Other clinically significant results included a decrease in fall rates and medication errors (Sand-Jecklin, Sherman, 2013 [4a]), as well as an increase in nursing satisfaction, and an overall decrease in overtime leading to financial savings (Tidwell et al., 2011 [4a]).

**Reference List:**

Maxson, P., Derby, K., Wroblewski, D., & Foss, D. (2012). Bedside nurse-to-nurse handoff promotes patient safety. *Medsurg Nursing: Official Journal Of The Academy Of Medical-Surgical Nurses*, 21(3), 140-144. Retrieved from Medsurg Nursing: <http://www.prolibraries.com/amsn/?select=publicationlist&resourceID=1> [4a]

Radtke, K. (2013). Improving patient satisfaction with nursing communication using bedside shift report. *Clinical Nurse Specialist CNS*, 27(1), 19-25. doi:10.1097/NUR.0b013e3182777011. [4a]

Riesenberg, L., Leitzsch, J., & Cunningham, J. (2010). Nursing handoffs: a systematic review of the literature. *The American Journal Of Nursing*, 110(4), 24-34. doi:10.1097/01.NAJ.0000370154.79857.09.[1b]

- Sand-Jecklin, K., & Sherman, J. (2013). Incorporating bedside report into nursing handoff: evaluation of change in practice. *Journal Of Nursing Care Quality*, 28(2), 186-194. doi:10.1097/NCQ.0b013e31827a4795.[4a]
- Thomas, L., & Donohue-Porter, P. (2012). Blending evidence and innovation: improving intershift handoffs in a multihospital setting. *Journal Of Nursing Care Quality*, 27(2), 116-124. doi:10.1097/NCQ.0b013e318241cb3b.[4b]
- Tidwell, T., Edwards, J., Snider, E., Lindsey, C., Reed, A., Scroggins, I., & Brigance, J. (2011). A nursing pilot study on bedside reporting to promote best practice and patient/family-centered care. *The Journal Of Neuroscience Nursing: Journal Of The American Association Of Neuroscience Nurses*, 43(4), E1-E5. doi:10.1097/JNN.0b013e3182212a1d.[4a]

## IMPLEMENTATION

### Applicability Issues:

Recommendation adherence will require the support of administration, unit managers, and nursing leaders to act as champions of change. It will be important for this support team and nursing staff to understand and be able to articulate the identified goals and outcomes to be achieved by implementing bedside nursing report to the nursing staff. Creating a standardized reporting sheet, which will include a head to toe assessment report, electronic medical record check, patient plan of care check, safety check, and introductory cues for communicating with the patient and family, will support the implementation of this change. In addition, patient assignments should be allocated to the same nurse if possible, to help with clustering report. Providing staff with adequate time to become accustomed to the new report methods and also encouraging their feedback can help resolve issues and identify areas of concern and assist them in the transition.

### Relevant CCHMC Tools for Implementation:

CCHMC Policy number CPC-I-103: Safe Handoffs of Care

SG Form No. 100216: Authorization for Use and/or Disclosure of Limited Protected Health Information

### Outcome or Process Measures:

Benchmark data can be collected quarterly in regards to patient satisfaction based on survey questions. With the implementation of bedside nursing report, the goal would be to increase the patient satisfaction scores to meet these benchmark measures since all could be affected by this change.

The charge nurse for each shift should be responsible for tracking if every nurse is participating in nurse to nurse bedside report for families that choose this option.

A unit based survey can be used to measure patient/family satisfaction in regards to nursing report prior to change, for a baseline, and then again after implementation of bedside report.

## SUPPORTING INFORMATION

### Background/Purpose of BESSt Development:

In an attempt to meet the Joint Commission's National Patient Safety Goals to improve staff communication, as well as individual unit benchmark patient satisfaction goals in accordance with Magnet Certification, a search of the literature was needed to find evidence to improve current report processes.

### Search Strategy:

*Databases:* PubMed, Cochrane Library, CINAHL, OVID Medline

*Search Terms:* Nursing; handoff; shift report; patient satisfaction; bedside handoff

*Limits, Filters:* English language, Search dates: 2006- 2013

*Date last searched:* 2/26/13

### Relevant CCHMC Evidence-Based Documents:

None were found

### Group/Team Members:

*Team Leader/Author:* Sarah Barker, RN, BSN

*Team Members:* Kathleen Dressman RN, MS, Senior Clinical Director, TCC, A7C1 Complex Pulmonary; Deborah Warden RN, BSN, Clinical manager, A7C1 Complex Pulmonary

*Support/Consultant:* Patti Besuner RN, MN, EBP Mentor, Center for Professional Excellence, Research, & Evidence Based Practice

**Conflicts of Interest were declared for each team member:**

- No financial or intellectual conflicts of interest were found.
- No external funding was received for development of this BESr.
- The following conflicts of interest were disclosed:

**Note:** Full tables of the [LEGEND evidence evaluation system](#) are available in separate documents:

- [Table of Evidence Levels of Individual Studies by Domain, Study Design, & Quality](#) (abbreviated table below)
- [Grading a Body of Evidence to Answer a Clinical Question](#)
- [Judging the Strength of a Recommendation](#) (dimensions table below)

**Table of Evidence Levels** (see note above):

Quality level	Definition
1a† or 1b†	Systematic review, meta-analysis, or meta-synthesis of multiple studies
2a or 2b	Best study design for domain
3a or 3b	Fair study design for domain
4a or 4b	Weak study design for domain
5a or 5b	General review, expert opinion, case report, consensus report, or guideline
5	Local Consensus

†a = good quality study; b = lesser quality study

**Table of Language and Definitions for Recommendation Strength** (see note above):

Language for Strength	Definition
It is strongly recommended that... It is strongly recommended that... not...	When the dimensions for judging the strength of the evidence are applied, there is high support that benefits clearly outweigh risks and burdens. <i>(or visa-versa for negative recommendations)</i>
It is recommended that... It is recommended that... not...	When the dimensions for judging the strength of the evidence are applied, there is moderate support that benefits are closely balanced with risks and burdens.
There is insufficient evidence and a lack of consensus to make a recommendation...	
<i>Given the dimensions below and that more answers to the left of the scales indicate support for a stronger recommendation, the recommendation statement above reflects the strength of the recommendation as judged by the development group. (Note that for negative recommendations, the left/right logic may be reversed for one or more dimensions.)</i>	
<b>Rationale for judgment and selection of each dimension:</b>	
<b>1. Grade of the Body of Evidence</b>	<input type="checkbox"/> High <input checked="" type="checkbox"/> Moderate <input type="checkbox"/> Low
<i>Rationale:</i> Multiple studies, weaker designs, consistent results	
<b>2. Safety/Harm (Side Effects and Risks)</b>	<input checked="" type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Serious
<i>Rationale:</i> Improved communication through bedside reporting increased accountability and a feeling of greater safety for patients (Maxson, Derby, Wroblewski, 2012, [4a]).	
<b>3. Health benefit to patient</b>	<input checked="" type="checkbox"/> Significant <input type="checkbox"/> Moderate <input type="checkbox"/> Minimal
<i>Rationale:</i> Patient outcomes of falls and medication errors decreased within a month of bedside reporting implementation (Sand-Jecklin, Sherman, 2013, [4a]).	
<b>4. Burden on patient to adhere to recommendation</b>	<input type="checkbox"/> Low <input checked="" type="checkbox"/> Unable to determine <input type="checkbox"/> High
<i>Rationale:</i> Patient's families get to choose whether they want to be a part of bedside report	
<b>5. Cost-effectiveness to healthcare system</b>	<input checked="" type="checkbox"/> Cost-effective <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not cost-effective
<i>Rationale:</i> Bedside shift report was shown to decrease overtime by nurses (Riesenburg, Leitzsch, & Cunningham, 2010 [1b]).	
<b>6. Directness of the evidence for this target population</b>	<input checked="" type="checkbox"/> Directly relates <input type="checkbox"/> Some concern of directness <input type="checkbox"/> Indirectly relates
<i>Rationale:</i> Intervention applicable for all hospitalized patients	
<b>7. Impact on morbidity/mortality or quality of life</b>	<input type="checkbox"/> High <input checked="" type="checkbox"/> Medium <input type="checkbox"/> Low
<i>Rationale:</i> Intervention has shown an increase in patient satisfaction and patient safety and promotes patient participating in their own plan of care. Also has shown decreased medication errors and falls (Maxson, Derby, Wroblewski, 2012 [4a]).	

Copies of this Best Evidence Statement (BES) and related tools (if applicable, e.g., screening tools, algorithms, etc.) are available online and may be distributed by any organization for the global purpose of improving child health outcomes.

Website address: <http://www.cincinnatichildrens.org/service/i/anderson-center/evidence-based-care/bests/>

Examples of approved uses of the BES include the following:

- Copies may be provided to anyone involved in the organization's process for developing and implementing evidence based care;
- Hyperlinks to the CCHMC website may be placed on the organization's website;
- The BES may be adopted or adapted for use within the organization, provided that CCHMC receives appropriate attribution on all written or electronic documents; and
- Copies may be provided to patients and the clinicians who manage their care.

Notification of CCHMC at [EBDMinfo@cchmc.org](mailto:EBDMinfo@cchmc.org) for any BES adopted, adapted, implemented, or hyperlinked by the organization is appreciated.

Please cite as: Barker, S., Cincinnati Children's Hospital Medical Center: Best Evidence Statement Increasing Patient Satisfaction by Moving Nursing Shift Report to the Bedside, <http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/best.htm>, BES 170, pages 1-4, 8/12/13.

This Best Evidence Statement has been reviewed against quality criteria by two independent reviewers from the CCHMC Evidence Collaboration. Conflict of interest declaration forms are filed with the CCHMC EBDM group.

Once the BES has been in place for five years, the development team reconvenes to explore the continued validity of the recommendation. This phase can be initiated at any point that evidence indicates a critical change is needed. CCHMC EBDM staff performs a quarterly search for new evidence in an horizon scanning process. If new evidence arises related to this BES, authors are contacted to evaluate and revise, if necessary.

*For more information about CCHMC Best Evidence Statements and the development process, contact the Evidence Collaboration at [EBDMinfo@cchmc.org](mailto:EBDMinfo@cchmc.org).*

#### **Note:**

**This Best Evidence Statement addresses only key points of care for the target population; it is not intended to be a comprehensive practice guideline. These recommendations result from review of literature and practices current at the time of their formulation. This Best Evidence Statement does not preclude using care modalities proven efficacious in studies published subsequent to the current revision of this document. This document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to this Statement is voluntary. The clinician in light of the individual circumstances presented by the patient must make the ultimate judgment regarding the priority of any specific procedure.**