Nurs Admin Q
Vol. 30, No. 2, pp. 112–122

Nurse Shift Report

Who Says You Can't Talk in Front of the Patient?

Cherri D. Anderson, MBA, RN, C;
Ruthie R. Mangino, MSN, APRN-BC

Bedside nurse shift report is a process where nurses provide shift-to-shift report at the patient's bedside so the patient can be more involved in his or her care. There are many benefits of bedside report, including relationship building between staff members and increased patient satisfaction, to both the patient and to the healthcare team. Concerns about the traditional methods of communication between the various shifts helped drive a nursing unit's decision to move to a more patient-involved model of shift-to-shift report. The change from the traditional taped report between healthcare providers to bedside reporting focused on patients wanting more involvement in their care, activities, and current status. Patients also wanted updates about their health status, their medical plan as well as information about their progress toward their goals. This, coupled with Banner Desert Medical Center's Care Model, embraces patient-centered care, King's Theory of Goal Attainment, and keeps the patient informed. The current nursing shift report did not meet the medical center's model of care on any of these aspects. This article will include information on the benefits of bedside nurse shift-to-shift report, how one unit implemented bedside reporting, and some of the outcomes achieved after implementing this change at a 600-bed urban medical center. **Key words:** *bedside shift-to-shift report*, *keeping patients informed*, *patient-centered care model*, *patient participation*, *nurse shift report*

AMERICAN SOCIETY demands and enjoys unparalleled access to information of all kinds. Current healthcare users desire and actively seek out information regarding disease processes and treatment options. There is evidence that active patient participation in care produces better health outcomes. Patients informed about their healthcare are more likely to participate in that care.[1,2] Providing nurse-to-nurse shift report at the patient's bedside puts the patient central to all information surrounding care activities. Bedside report also allows the patient access to his or her immediate care and health information and promotes patient ease of mind leading to a speedier recovery. In addition, bedside reporting makes it possible for nurses starting a shift to obtain significant data to be able to prioritize patient care and manage their patient load effectively.[3] This article reviews the challenges and rewards of implementing bedside nurse shift-to-shift report on a 32-bed general surgical unit, which is part of a 600-bed tertiary care hospital in a large metropolitan area in the southwestern United States.

From the Adult Acute Care Unit, Banner Desert Medical Center, Mesa, Ariz.

Corresponding author: Cherri D. Anderson, MBA, RN, C, Adult Acute Care Unit, Banner Desert Medical Center, 1400 S Dobson Rd, Mesa, AZ 85202 (e-mail: cherri.anderson@bannerhealth.com).

BACKGROUND DATA

Nursing care at Banner Desert Medical Center (BDMC) is based on Imogene King's Theory of Goal Attainment, which includes 3 interacting systems—personal, interpersonal, and social. The BDMC's patient care delivery model (the "Care Model") utilizes this theoretical framework to view the nurse and patient interaction. The Care Model maintains a basic assumption that nursing is a process that involves caring for human beings whose

ultimate goal is health.[4] King stated, "Although personal systems and social systems influence quality of care, the major elements in a theory of goal attainment are discovered in the interpersonal systems in which two people, who are usually strangers, come together in a healthcare organization to help and to be helped to maintain a state of health that permits functioning in roles."[4(p142)] Bedside nurse report supports this theory by allowing the nurse and the patient an opportunity to share information, ask questions, and plan individualized interventions and outcomes the patient requires and deserves.

The process of bedside nurse report is just one facet of the Care Model at the BDMC. In the hospital's Care Model, the underlying principle is the "patient is at the center." There are many components of the Care Model but the "must haves" of the model are the critical success factors. These factors include communication, collaboration, informing, nursing care, patient data, holistic care, clinical excellence, teams, and compassion. All of these factors, as well as the Care Model as a whole, are about keeping the patient informed and at the center of all decisions regarding care. Bedside report includes all of these critical success factors.

DRIVING FORCES

The advent of the Internet has allowed many patients access to medical knowledge and treatment choices at his or her fingertips that were not previously available. As patients become more knowledgeable consumers of healthcare, they understand that they have certain rights and desire more education and knowledge. This allows them more information about their care and disease processes and to be able to make better choices about their immediate healthcare needs. Coupled with this easily accessible information and our aging populations living longer, more acute care is being required. Acute care patients want more active involvement in their illness trajectory.[1,2]

Another driving force for today's healthcare consumers is the patients' desire to move from a parental model of care to a more collaborative model of care. Until recently, physicians and healthcare experts maintained exclusive rights over medical knowledge and decided "what was best" for the patient (parental model). Today patients want to be involved or at least informed about healthcare options and alternatives (collaborative model).[1,2] Bedside nurse reporting supports this model of informed choice and active patient participation.

The nurse also needs information about the patients he or she will be caring for. This is typically done as a "change of shift" report. Staff nurses view change-of-shift report as a critical event for exchanging patient information. To ensure continuity of care when the care is transitioned to the next nursing caregiver, the report must be broad enough to encompass the holistic and long-term goals of the patient, yet specific enough to meet short-term goals and offer individualized preferences to meet the patient needs. Traditional methods of shift report such as verbal and taped report tend to be lengthy, inconsistent, and have missing or incorrect elements of patient information. The content sometimes digresses to irrelevant or judgmental statements. This can lead to negative preconceptions by the oncoming nurse, omissions of relevant patient care, and complaints from patients, families, and physicians.[5]

Traditional taped or verbal reports offered only minimal communication between nurses and nursing assistants, thus eliminating some required elements of nurse delegation. Other concerns about the traditional methods of shift-to-shift report include incomplete information about patient care and having questions that cannot be answered or addressed once the previous nurse is gone. This can hamper shift-to-shift nurse relationships. Deficient communication during shift report can create additional problems including decreased patient safety. Bedside shift-to-shift report offers options to address the inefficiencies of traditional nurse reporting.

BENEFITS

The interaction of nurses and patients with the change of caregivers provides benefits to the patients as well as to the staff nurses. Bedside shift report reassures the patient that the staff works as a team and that everyone knows the plan of care. Patients can ask questions or add information to the discussion. Evidence suggests that better informed patients are less anxious and more likely to follow medical advice.[6] Informed patients are apt to start treatments earlier and thus be able to select lower risk interventions. Evidence also suggests that patients involved in their care are more satisfied and litigate less.[6] Increased patient satisfaction translates into loyal customers who are more likely to return for care and services. Also, healthcare costs drop through more self-management by patients and more efficient use of resources.

Benefits of bedside reporting for the staff nurse include the oncoming nurse's ability to visualize patients immediately and prioritize care for the shift. This also assists the nurse to be more prepared to answer physician questions when asked and better able to delegate care activities to assistive personnel. Experiential learning also occurs at the bedside when nurses can demonstrate equipment use and share information related to individualized patient needs. Accountability between shifts is promoted by immediate visualization of patient needs by both shifts. Staff relationships are improved as communication between shifts is now face to face, thus building teamwork and decreasing blame.

THE INTERVENTION: BEDSIDE REPORT

Bedside report is nurses providing shift-to-shift report at the patient's bedside so the patient can be more involved in his or her care. To begin with, the oncoming nurse and nursing assistant or unlicensed assistive personnel (UAP) obtain the information about their patient assignments off the traditional Kardex. This same nurse/UAP team then locates the off-going nurse for each patient that he or she is assigned to. Report takes place at the patient's bedside using the "guidelines for report" pocket guide to ensure individualized yet comprehensive exchange of information. The patient is encouraged to participate in the information being communicated so that all parties are knowledgeable about the patient's plan of care. Individualized report takes about 2 to 3 minutes per patient. After receiving report the nurse then identifies each patient's priorities, the "team" priorities, and communicates appropriately with the UAP by assigning individual patient priorities on the UAP delegation list. Team "huddles" are encouraged every 3 to 4 hours to exchange any new and updated information between the nurse and the UAP regarding patient status and needs. At the end of the shift, the UAP reports back to the nurse, communicating any additional information as necessary (bath not completed etc). The nurse then initials the UAP's assignment sheet, ensuring the closure of delegation per the State Board of Nursing requirements.

CHALLENGES

Implementing change in an environment as complex as healthcare can be an overwhelming venture, to say the least. Bridges believes that change involves a shift in the external environment, and that transition is internal in that it is the psychological reorientation by the individual in response to the change.[7] People cannot control change but can control transition or how they respond to the external change.[7] Inundated with changes on a continual basis, staff nurses seek to exercise some control over this environment by developing and adhering to routines, thus controlling the transition (internal change). Nurses claim this assists them in ensuring tasks are completed and identified patient care needs are not left undone or missed. Most staff members prefer to hang on to the comfort of these routines or "status quo" even if current processes are frustrating and ineffective. Other staff members harbor cynicism and pessimism because of past failed efforts of change regardless of

the reasons, thus making the transition process harder.

In addition, change can be hampered by lack of a shared vision. Without a clear direction in mind, a suggestion for change has no context to a team of staff members.[8] As people go through the transition, a clear vision keeps them focused on an end goal of what is to be accomplished.[7] Having measurable outcomes like satisfaction and financial information helps keep the vision alive with staff and ensure movement in the correct direction.

With discussion of implementing bedside nurse shift report at the BDMC, the staff was overheard discussing challenges of changing shift-to-shift report. The leadership team and most of the staff understood that the current processes of shift-to-shift report were ineffective and not a good fit for our patient care delivery model. The staff expressed concerns related to lack of confidence with a nontraditional method of reporting, issues with confidentiality, and fear of situations where patients would talk or ask questions for extended periods, thus increasing length of time for the report. Other concerns were related to the actual process itself, such as what to do if the patient does not know the diagnosis or test results yet; what if the patient is sleeping; and what if the patient is uncooperative with care and it needs to be reported to the oncoming shift.

The benefits of the proposed bedside report based on traditional report inefficiencies and identified problems with the current report process offer an immediate solution to many of the problems identified with other traditional methods. This new style of report is informative, shorter, more individualized, and involves the patient. It provides a win-win situation for the staff as well as the patients.

IMPLEMENTATION

One of the Adult Acute Care units at the hospital was chosen to implement bedside nurse reporting after many other facets of the Care Model were implemented and the nurses had incorporated the changes into their practice. This general surgical unit was one of the original units for implementing the hospital's care delivery model. This unit was chosen because of its willingness to embrace new challenges, including the challenge of implementing bedside nurse report. A defined, methodical process was utilized to implement bedside report that included staff information and education of the process with ongoing feedback and evaluation. This process included the following steps:

1. *Building a team:* The first step to putting bedside report into operation was to "build" a team. This included the unit's formal leaders as the management support as well as informal leaders on the unit who were willing to support change. Unit champions were also identified as staff who remain positive in the face of challenge and act as agents of change. The unit was also fortunate enough to have a few staff members who had utilized bedside nurse shift report previously and could serve as agents of change.
2. *Identifying the goals and outcomes:* Bridges states that when those affected by the change are involved in the change process, the transition is easier.[7] Sharing a common vision is key to making and sustaining a process change. It was important for the core team to understand and be able to articulate the identified goals and outcomes to be achieved by implementing bedside nurse reporting. The group developed a goal of implementing bedside nurse report. Outcomes were also identified, and included increased patient and staff satisfaction and financial savings. Keeping the goals and outcomes as the focus, the core team provided education, answered questions, and role-modeled desired behaviors for other staff on the unit. They developed case studies, anticipated where resistance would be met, and developed strategies to minimize conflict with the change and transition processes. The team also developed

guidelines with key words and phrases outlining the key communication areas to help individual staff transition to the new report process.

3. *Making implementation a priority:* The new process for shift report became a priority for the unit for several months; no other changes were introduced for at least 6 weeks while this change was being implemented. Identifying this change as a priority by management-assisted staff to identify the change as a priority as well, thereby increasing chances of success. By increasing a sense of priority, staff was more motivated into action.[8] A firm date and time for the new shift report change were identified and communicated along. In addition, immediate postimplementation meetings were posted for staff to be able to resolve issues and identify areas of concern and assist them in the transition.
4. *Gathering baseline data:* The team identified measures to determine the impact of bedside nurse report. The team decided to measure staff satisfaction as well as patient satisfaction. Satisfaction surveys of the entire unit staff regarding the current report process were conducted before implementation and then again after implementation. Patient satisfaction scores in 4 key areas were measured before the implementation as well as after the implementation of the bedside nurse report. The 4 patient satisfaction questions identified were from the current hospital satisfaction survey. The chosen questions ranked high in the priority index for patient satisfaction and provided an indirect means to measure the patients' response to bedside report. Another measure identified to gather outcomes was the financial impact of the new report process. Financial data for time over shift (incidental time) for the 2 months preimplementation and then 2 months postimplementation were to be collected to determine the financial outcomes this process change had on the unit's operational budget.
5. *Educating the team:* Learning needs were identified for the patient and the staff regarding the new shift report process, the goals, and the expected outcomes. Staff education on the new shift report process was completed using multiple methods. Sessions were done at various times of the day and night to accommodate all shifts and included a case study. Posters and flyers announcing the change were posted on the unit. E-mails were also sent to the staff with more information. Staff members who had utilized bedside reporting were part of the education team. Education was done within 2 weeks of the "go live" date to enhance staff retention of newly learned information.

During the educational offerings the initial focus was on benefits to the staff. By focusing on the "WIIFM" (what's in it for me), the staff was more apt to accept the change.[7] Specifics regarding bedside reporting including written handouts and practice sessions were provided during classroom education. Information included how to introduce the oncoming team and report process to the patient, report content, maintaining patient privacy, exit statements, and how to address unusual circumstances (such as patient is asleep, new diagnosis, patients who choose not to follow medical advise, etc).

Patient education included the off-going staff reinforcing the patient "welcome letter," which included information regarding bedside report. Staff would inform the patient about getting involved and participating in the report.

6. *Providing resources:* Multiple resources were provided to the staff to ensure successful implementation of the report change. This included 1-page written handouts, laminated pocket guides that could be carried in staff pockets, a unit manual with detailed content, and identified

personnel resources. Also, the responsibilities of each team member for the new process were clearly identified. In addition, a formal patient letter was written regarding the process of bedside nurse report and provided to each new patient.

7. *Celebrations and feedback:* A celebration was planned for implementation date and 1-month postimplementation. Verbal praise and rewards were provided for even small successes. Management interviewed patients regarding the new process and provided feedback and recognition to the staff immediately. Patient satisfaction scores were posted on the unit and reviewed each month at the unit's shared leadership meeting. Rewards were provided in both individual and group settings based on individual staff preference.

EVALUATION

The process of bedside reporting was implemented with minimal resistance and negligible unit disruption. Thorough planning and training, staff involvement, and open discussions regarding the change made the process more successful. Ongoing feedback was provided to the staff regarding their performance of the new process and positive behaviors were rewarded. Staff who had utilized the process before provided clarification and support to the staff and talked positively about the change. The management team was key in reinforcing the new process through continuous coaching, supervision, and mentoring.

The biggest challenge encountered in implementing bedside report was incorporation of the nursing assistant staff in the report process. Ideally each licensed nurse and the assigned nursing assistant coming on shift would go on rounds together and receive report on patients, thus allowing for delegation as required by the nurse practice acts. The number of licensed staff was more than the unlicensed staff, making this approach difficult. Based on input from staff, the solution was for the nursing assistant to go on rounds with the nurse whom she shared the greatest patient assignment and then communicate with the other nurse(s) prior to initiating patient care. This ensured that the nurses were prioritizing and delegating the plan of care and that the nursing assistants were practicing within their defined job description.

OUTCOMES

Several outcomes, including financial savings and increased patient, staff, and physician satisfaction, were observed on the unit after the implementation of bedside nurse shift report. One financial outcome was a decrease in time over shift (incidental time) by over 100 hours in the first two pay periods after the implementation of bedside report. A decrease of over 100 hours was again achieved on the next two pay periods after the implementation of bedside report (Fig 1). Bedside shift-to-shift report takes less time than traditional taped report, which translates into financial savings.

Another outcome included numerous staff members positively commenting about being able to better prioritize their shift work because they have visualized all of their patients within the first 20 to 30 minutes of their shift. Figure 2a shows increased satisfaction of the licensed staff in all areas including accountability, interpersonal relationships, and receiving pertinent information. The unlicensed staff survey did not show an increase in staff satisfaction with the new report process as shown in Figure 2b. This was attributed to enforcement of licensed staff delegating priorities and care to the UAP instead of traditional UAP-to-UAP report.

An unanticipated outcome of bedside report involved increased physician satisfaction. The chief nursing officer informed the unit's management team that the physicians' were reporting "more informed" nurses when they called the unit to inquire about their patients. Most notably, the physicians reported not hearing "I don't know, I haven't seen the

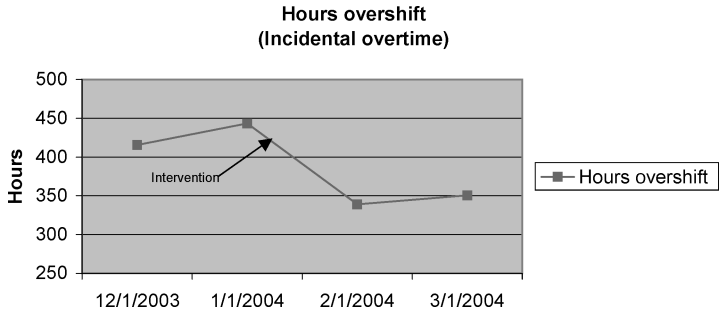

Figure 1. Hours over shift before and after the implementation of bedside report.

patient yet" from the nurses. Patients also commented positively to their physicians about bedside report.

Bedside report also impacted our patients positively. Doing report in front of the patient reassured the patient that everyone knows what is going on and that the patient was the priority. The outcome measure of this included informal daily rounds by the managers on the unit as well as the hospital patient satisfaction survey. The 4 key areas monitored on the patient satisfaction scores for the unit were (*a*) how well the nurses kept you informed; (*b*) how well staff worked together to care for you; (*c*) how well your pain was controlled; and (*d*) staff effort to include you in decisions about your treatment. These results show an increase in patient satisfaction with the key elements around bedside report (Figs 3–5).

The patient satisfaction question related to pain was dropped from our outcome measures after several months because asking about pain did not reflect pain management satisfaction. We initially saw an increase in the pain survey question along with the others, but with no intervention specific to the treatment of pain, the score later stabilized to preimplementation levels. Thus, it was felt that this was not a good indicator of bedside report effectiveness.

During the manager's rounds on patients, overwhelming patient satisfaction was also reported with many patients stating "I feel safe," "I know who my caregivers are," and "I know what's going on." In addition to satisfaction with current care, evidence shows that patient satisfaction translates to returning customers, which is directly linked to profitability and return on investment.[9]

Another positive outcome achieved involved compliance with scope of practice. By utilizing the approved UAP delegation sheet to prioritize care by the nurse, the UAPs do not have to independently identify patient goals and expected outcomes. When the UAP returns the sheet to the registered nurse at the end of the shift, the nurse's initials indicate that communication and evaluation of the delegated skills are completed or an action plan formulated.

IMPLICATIONS FOR PRACTICE

Increased patient satisfaction was seen with the implementation of bedside shift report. By involving the patients in their plan of care and keeping all caregivers updated on that plan, patients feel more secure, and are more likely to participate in their own care and follow recommended healthcare options. These satisfied patients are more likely to become loyal customers and return to the facility for future care.

Increased staff satisfaction with bedside report encourages teamwork for all shifts, promotes staff accountability, and ensures the nurse receives pertinent information about the patient. The ability to prioritize patient care as well as patient assignments may translate to increased staff satisfaction and engagement. This could lead to retention,

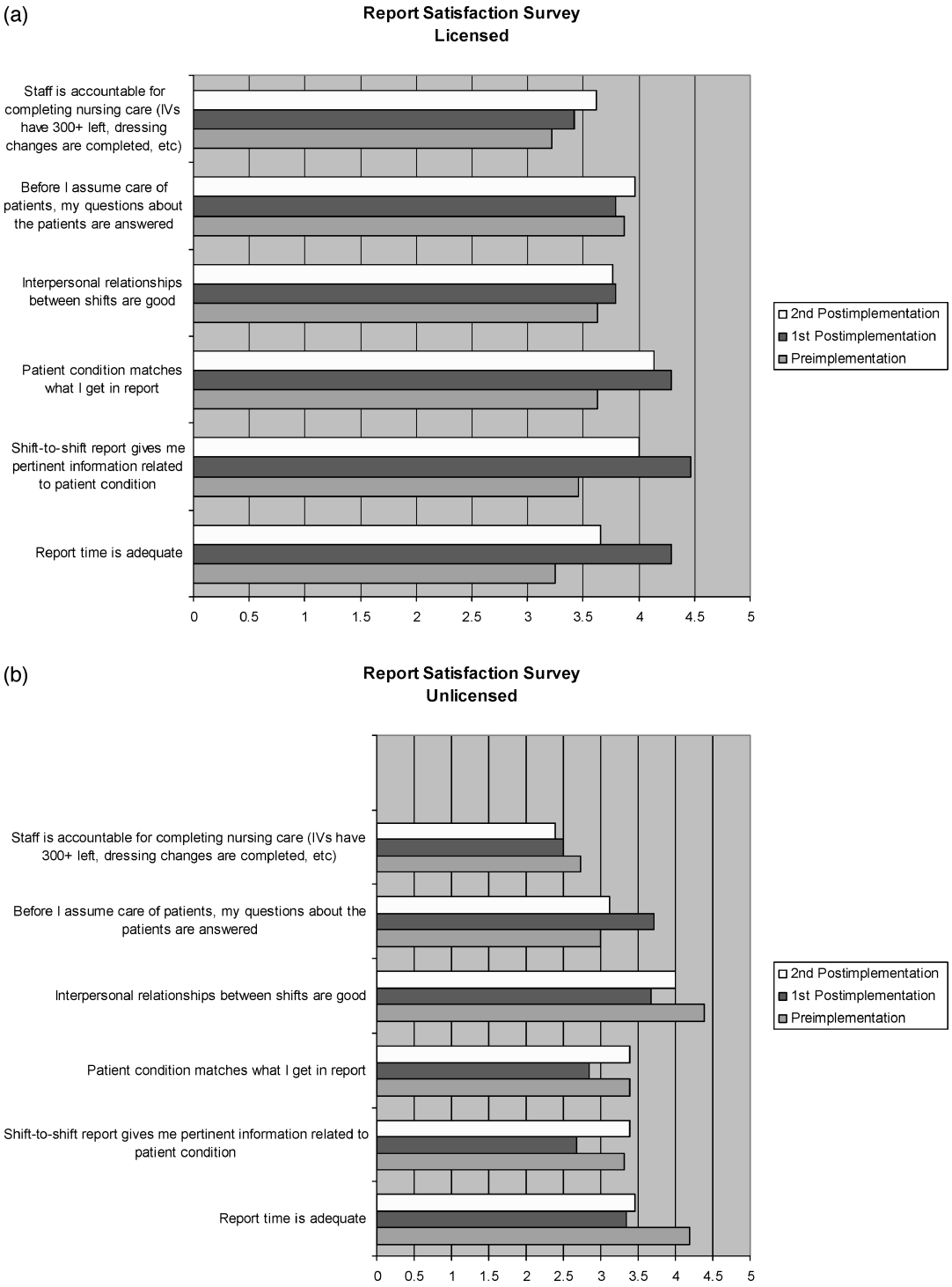

Figure 2. Licensed staff report satisfaction survey results (a); unlicensed staff report satisfaction survey results (b).

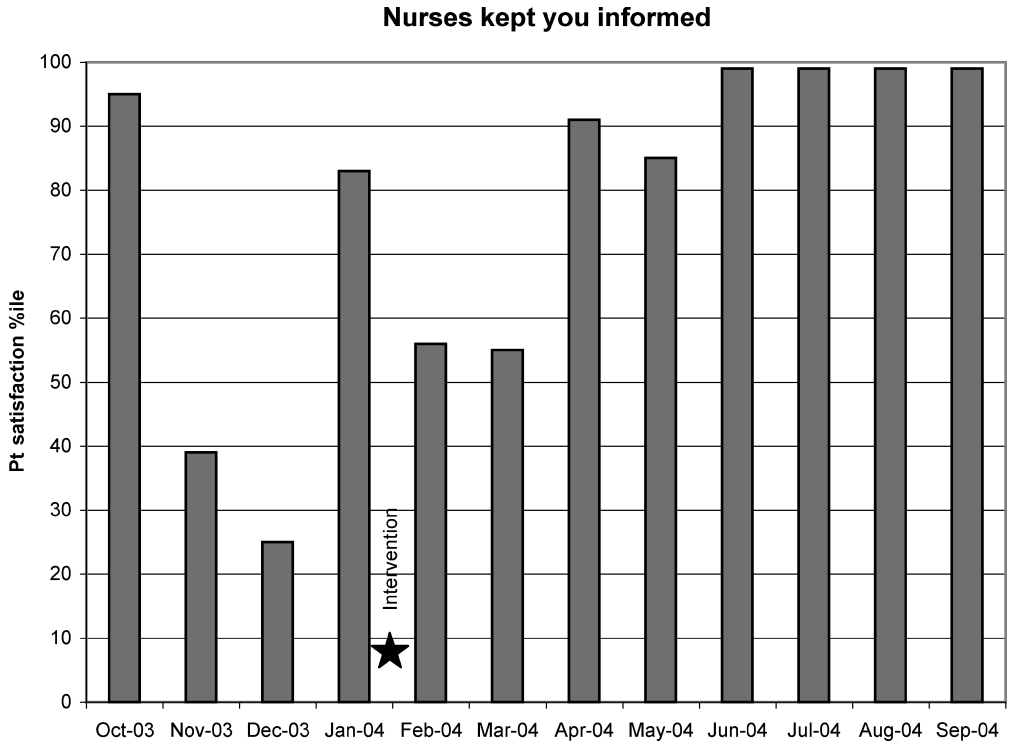

Figure 3. Patient satisfaction survey results for "how well the nurses kept you informed?"

Figure 4. Patient satisfaction survey results for "how well staff worked together to care for you?"

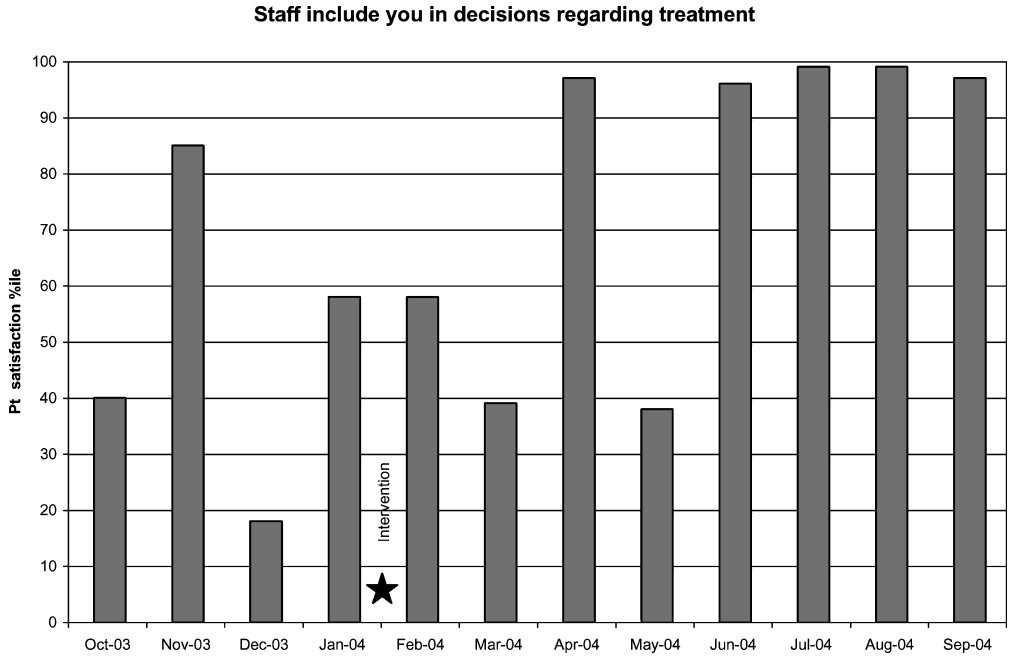

Figure 5. Patient satisfaction survey results for "staff effort to include you in decisions about your treatment."

decreased turnover costs, and positively affect financial outcomes. Achieving positive financial outcome allows for more budgetary options.

SUMMARY

Healthcare providers are barraged with managing complex medical information, technology, and growing customer demands and expectations. Using traditional communication techniques, such as taped or verbal report, no longer meets the current patients' needs. Market forces, financial constraints, and consumer demands require that patients be more involved in their care and bedside shift report is one way of meeting these needs. Bedside shift report brings the patient closer to the goal of collaborative decision making and increases patient satisfaction.

REFERENCES

1. Rednova News. Promoting informed choice: transforming health care to dispense knowledge for decision making. 2005. Available at: http://www.rednova.com/modules/news/tools.php?tool=print&id=214457. Accessed September 11, 2005.
2. Kravitz RL, Melnikow J. Engaging patients in medical decision making. *BMJ.* 2001;323:584–585.
3. Kassean H, Jagoo G. Managing change in the nursing handover from traditional to bedside handover—a case study from Mauritius. *BMC Nurs.* 2005;4(1):1–10.
4. Williams LA. Imogene King's Interacting Systems Theory—applications in emergency and rural nursing [online]. *RNO.* 2001;2(1). Available at: http://www.rno.org/journal/issues/Vol-2/issue-1/Williams.htm. Accessed September 11, 2005.
5. Elm J. Improving labor and delivery shift report. *WHONN Lifelines*. 2004;8(1):54–59.
6. Singleton P. The informed patient study: the way forward for Europe [PowerPoint, University of Cambridge Website]. Available at: http://www.ehfg.org/typo3/fileadmin/Image_Archive/Website/Archiv/

2005/Power_Points/L_1/L1_Singleton_final.ppt. Accessed September 11, 2005.
7. Bridges W, ed. *Managing Transitions: Making the Most of Change*. 2nd ed. Cambridge, Mass: Da Capo Press; 2003.
8. Silversin J, Kornacki MJ. Implementing change: from ideas to reality. *Fam Pract Manag.* 2003. Available at: http://www.aafp.org/fpm/ 20030100/57impl.html. Accessed January 1, 2004.
9. Dimensional Insight. Lee Memorial Health Systems: increasing patient satisfaction and growing margins through business intelligence. 2005. Available at: http://www.hospitalanalysis.com/CustomerProfiles. Accessed September 2, 2005.