Winter 12-7-2020

Standardized Bedside Report During the Transfer of Care

Lauryn Fanning-Goff
lfanning@patriots.uttyler.edu

Standardized Bedside Report Benchmark Study

In Partial fulfillment of NURS 5382: Capstone

The University of Texas at Tyler School of Nursing

By

Lauryn Fanning

December 5, 2020

The Joint Commission (2017) estimates that 80% of serious adverse events occur because of ineffective communication that occurred between caregivers during patient handoff. This creates the need for improvements in communication during the handoff process. In surgical services specifically, multiple patient transfers can happen in a short amount of time, increasing the opportunities for communication failures significantly. This increases with each subsequent handoff, creating a potential for critical data to be missed and serious safety events (The American Society of PeriAnesthesia Nurses [ASPAN], 2016).

The utilization of a standardized form of handoff is supported as a way to ensure critical information is not omitted to lead to optimal patient care and satisfaction (Salzwedel et al., 2013). With communication errors being correlated to sentinel or adverse events during patient care, it is important to continuously assess and improve current communication practices within organizations. Evidence has showcased that the use of standardized reports at the bedside is the new standard when communicating patient information with nursing staff, patients, and families.

Optimization of our communication processes can prevent multiple adverse/sentinel events that will also prevent the organization from potentially being held liable to cover those costs. The use of a standardized form of handoff is supported by literature as a way to ensure critical information is not omitted. Completing the report at bedside allows the patient and family to be involved in care, improve patient safety, and enhance patient satisfaction scores (Baldwin & Spears, 2019). Because of this, the PICOT question is: “In staff nurses on a pediatric surgical unit (P), how would a standardized bedside report during the transfer of care (I) compared to standard procedures for transfer of care (C) affect omission of patient information (O) at 8 weeks after implementation (T)?”

Literature Synthesis

A literature review was conducted to evaluate the levels of evidence available that supported the utilization of a standardized report form at the bedside during transfer of care. Various levels of evidence were reviewed to see what practices were supported. The following paragraphs will highlight some of the evidence obtained during the literature search.

In the perioperative setting where multiple handoffs can occur in a short amount of time, Salzwedel et al., (2013) reported that the use of standardized reports increases the amount of patient information items that were handed over during transfer of care. In the Salzwedel et al., (2013) randomized control trial study, appropriate use of the standardized report form showed an increase in patient information items being handed off significantly. Because of this Salzwedel et al., (2013) recommended the use of a standardized report form that was carried with patients during all phases of care to ensure accurate and consistent information was reported during handoff.

With any practice change, compliance of nursing staff will be a challenge that needs to be addressed. By involving the nursing staff in the development of the bedside report practice and form, nurses become key stakeholders in the process change. Scheidenhelm & Reitz (2017) studied nursing compliance before and after the implementation of the standardized bedside report, showing an increase in nursing compliance to be significant. The major finding in this quasi-experimental study was that pre-implementation nursing staff were minimally compliant with the existing report process. This shows that patient information during handoff is subjective to different nurses. Scheidenhelm & Reitz (2017) also studied that patient satisfaction about communication increased significantly with question of “nurses kept you informed.”

With adverse reactions and sentinel events linked to communication failures, Mehta et al., (2018) studied how the use of standardized checklists could help reduce the amount of complications post-surgical intervention. Overall, this quasi-experimental study concluded that “implementation of SURPASS checklist is effective in reducing the rate of postoperative complications in both elective and emergency surgeries” (Mehta et al., 2018, p. 1).

Halterman et al., (2019) conducted a quality improvement project aimed to decrease the amount of patient information that can be omitted during the post anesthesia care unit (PACU) patient handoff. The study resulted not only in a decrease in patient information omission, but also, showed increased compliance with the report process between nurses. By the end of the study, utilization of the PACU handoff checklist showed that pertinent patient information is discussed during transfer of care with decreased omissions of critical information (Halterman et al., 2019).

An exploratory-descriptive qualitative study conducted by Bigani & Correia (2018) wanted to assess the nurse’s perceptions of communication during the report process. Three themes were identified: "barriers to conducting bedside report, patient safety, and impact on patient care" (Bigani & Correia, 2018, p. 85). By the end of this study, nurses reported that preferred this method of change-of-shift communication practice. Because of this, Bigani & Correia (2018) supports using bedside report during transfer of care between nursing staff.

Stakeholders

The stakeholders of this practice change will include bedside nurses, ancillary staff such as advance care technicians, certified registered nurse anesthesiologist (CRNA), and Medical Doctor of Anesthesiology (MDA). With so many key identified stakeholders, this will encourage inter-professional collaboration to discuss the current report process, barriers to change, and

ideas for improvement. The main barrier discussed was the resistance to change that more established healthcare staff might give off. The goal is that with approval from leadership, both unit and hospital based, collaboration between nurses and healthcare providers, and recognizing the need for change, this practice can be implemented with minimum resistance. Since barriers are a concern when implementing a practice change, Rodgers, Brown, & Hockenberry (2019) recommended analyzes why the barriers exist initially and then leadership to address these issues with staff.

Implementation

This practice change will first be initiated in our ambulatory surgery center with the anticipation that all perioperative services (inpatient and outpatient) will implement the practice change down the road. Our current ambulatory surgery center has six operating rooms, 22 prep/post-operative rooms, and six post anesthesia care unit beds. The current surgery volume at this facility (attached to the main hospital) is an average of three operating rooms, operating with an average patient census of 20-30 patients per day.

According to Rodgers, Brown, & Hockenberry (2019) clinical nurses are in the best position to see problems within healthcare organizations, which promotes engagement. Because of this, planning of this practice change will be initiated first by developing a task force of clinical nurses to analyze our current report process, review reported serious safety occurrences related to communication, surveying nurses to gain perspective on current report processes, and reviewing patient satisfaction scores related to communication. The task force will also evaluate the barriers that might occur when implementing a practice change. From there, the creation of a standardized report form will be created based on a nurse survey of what they believe is the most relevant information when caring for a surgical patient.

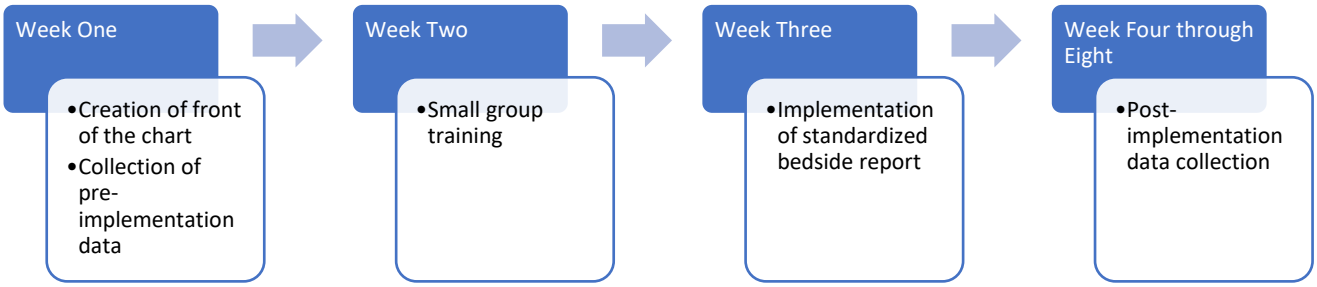
Implementation of this practice change will begin with staff education. Management, charge nurses, bedside, nurse, and ancillary staff (i.e. advance care technicians) will attend small group training and education. Small group training will include overview of standardized report form paper, role-playing of bedside report process, and feedback from staff. Implementation of practice change will be rolled out by all staff members on set date. Nursing staff and leadership will agree upon an implementation date and collect data for an eight week timeline to assess if the practice change improves communication based outcomes. Because of this, during the preimplantation stage will be four weeks long to complete all small group trainings, preimplantation data collection, and draft and editing of standardized bedside report form after consultation with all bedside nursing staff.

Iowa Model-Revised will be used to plan, implement, and evaluate this project. This change process was chosen because this model encourages healthcare professionals to improve current healthcare practices while being easy to apply (Dang et al., 2019). The utilization of the Iowa Model-Revised, will provide a structured outline of implementation steps for the task force to take for this practice change to be implemented smoothly, with anticipated barriers being recognized. The goal is for implementation to go as smoothly as possible with leadership and task force handling or removing frozen obstacles as much as possible.

Timetable (flowchart)

In previous semester, this PICOT question was developed with the intention of being initiated during the fall semester of 2020. Due to COVID-19 pandemic, the ambulatory surgery center was closed due to cancellation of all elective surgeries. Once the surgery center was re-opened, leadership recommending pausing on all new evidence based projects. The below

timeline showcases the proposed plan of implementation for the weight week period. The goal is begin implementation in the spring of 2021 upon leadership approval.



Data Collection Methods

Data collection will include a bedside report form, nurse satisfaction scores from survey, patient satisfaction scores from NRC database, and physical assessment times. Patient satisfaction scores (percentile scoring) will show an increased in question related to communication such as “reviewed consistent information” and “care providers explained things.” Current patient satisfaction scores are scored at 89.7%, which is above the national average, but the organization has the goal of reaching 98-100%. Nursing survey results will include most (more than 90%) of staff nurses either strongly agreeing or agreeing with questions related to communication such as “standardized report gives me the critical information necessary to assume care of a patient.” The bedside report form will show a completion rate of at minimum 90% with the goal of 100% completion to showcase that critical information is being reported throughout all phases of surgical care. Finally, physical assessment times will be analyzed to see a reduction is the amount of time between handoff and when the first assessment was documented. Currently, there is an average time of 10 minutes between the first document assessment. The goal would be to reach a time frame of five to seven minutes to showcase that

bringing a report to the bedside, improves the receiving nurse's ability to immediately assume care of the patient without having to look through electronic health records for information.

Discussion of Evaluation

There is not an official evaluation of this benchmark study at this time. However, there has been positive feedback and encourage all level of management for the implementation of this practice change.

Conclusion/Recommendations

With communication errors being correlated to sentinel or adverse events during patient care, it is important to continuously assess and improve our current communication practices. Evidence has showcased that the use of standardized reports at the bedside is the new standard when communicating patient information with nursing staff, patients, and families. Collaboration between bedside nurses, charge nurses, and nursing leadership, practice changes in communication can be implemented to ensure we provide the safest, evidence-based care.

References

Baldwin, K. M., & Spears, M. J. (2019, March/April). Improving the patient experience and decreasing patient anxiety with nursing bedside reports. *Clinical Nurse Specialist*, 82-89. http://dx.doi.org/10.1097/NURS.0000000000000428

Dang, D., Mazuerk Melnyk, B., Fineout-Overholt, E., Yost, J., Cullen, L., Cvach, M., . . . Stevens, K. R. (2019). Models to Guide Implementation and Sustainability of Evidence-Based Practice. In B. M. Melnyk & E. Fineout-Overholt (Authors), *Evidence-based practice in nursing and healthcare*: A guide to best practice (pp. 378-427). Philadelphia: Wolters Kluwer.

Halterman, R., Gaber, M., Janjua, M., Hogan, G., and Cartwright, S. (2019). Use of a checklist for the post-anesthesia care unit patient handoff. *Journal of PeriAnesthesia Nursing*, 34, 834-841. doi:10.1016/j.jopan.2018.10.007

Mehta, N., Amaranathan, A., Jayapal, L., Kundra, P., & Nelamangala Ramakrishnaiah, V. P. (2018). Effect of comprehensive surgical safety system on patients' outcome: A prospective clinical study. *Cureus*, 10, e2601. doi:10.7759/cureus.2601

Rodgers, C. C., Brown, T. L., & Hockenberry, M. J. (2019). Implementing evidence in clinical setting. In B. M. Melnyk & E. Fineout-Overholt (Authors), *Evidence-based practice in nursing & healthcare: A guide to best practice* (pp. 269-292). Philadelphia: Wolters Kluwer.

Salzwedel, C., Bartz, H.-J., Kühnelt, I., Appel, D., Haupt, O., Maisch, S., & Schmidt, G. N. (2013). The effect of a checklist on the quality of post-anesthesia patient handover: A randomized controlled trial. *International Journal for Quality in Health Care*, 25, 176–181. doi:10.1093/intqhc/mzt009

Scheidenhelm, S., & Reitz, O. E. (2017). Hardwiring bedside shift report. *Journal of Nursing Administration,* 47, 147–153. doi:10.1097/NNA.0000000000000457

The American Society of PeriAnesthesia Nurses. (2016). 2017-2018 Perianesthesia nursing standards, practice recommendations, and interpretive statements. Cherry Hill, NJ: ASPAN.

The Joint Commission. (2017). Inadequate hand-off communication. Retrieved from https://www.jointcommission.org/assets/1/18/SEA_58_Hand_off_Comms_9_6_17_FINAL_(1).pdf