

The Evolution of Nurse-to-Nurse Bedside Report on a Medical-Surgical Cardiology Unit

Change of shift report is unique to the nursing profession. During report, nurses transfer critical information to promote patient safety and best practices. Nurse-to-nurse bedside report is described as a strategy that includes the patient in the reporting process and is an innovative alternative to traditional shift report.

Shift report among nurses has been defined as “a system of nurse-to-nurse communication between shift changes intended to transfer essential information for safe, holistic care of patients” (Riegel, 1985, p. 12). Report, or handoff, is unique to the nursing profession. Although shift work is a common concept, nurses are not simply changing personnel during this critical moment. Change of shift signifies a time of careful communication in order to promote patient safety and best practices. The risk exists, however, for this critical opportunity of relaying important information to become muddled by irrelevant information instead of focusing on the needs of the patient. In addition, the person at the center of the communication — the patient — is seldom part of this process. Many different approaches to shift report exist, including written report, phone recording and tape recording with possible verbal updates, or verbal reports in a designated room, nurses’ station, or at the patient’s bedside. In the best of circumstances, the report will be patient-focused and patient care will proceed with minimal disruption.

In a qualitative study conducted by Kerr (2001), the researcher identified report as a highly complex communication event with multiple functions. This finding highlights the importance of continuous quality assessment and improvement of this critical nursing practice to ensure continuity in patient care and best practice. The importance of an informative and effective nurse-to-nurse report has been highlighted most recently in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) National Patient Safety Goals (NPSGs). The JCAHO recommends that organizations “implement a standardized approach to hand off communications, including an opportunity to ask and respond to questions” (p. 6). Attributes of effective handoff communication are further identified by JCAHO as interactive, up to date, and with limited interruptions.

Background

The medical-surgical cardiology unit described in this article is divided into three pods with 12 beds each. It is staffed according to an all-registered nurse (RN) model of care. Cardiology specialties include medical and surgical cardiology, heart transplantation, and ventricular assist device therapy. The unit is supported by a level II emergency department, a three-room cardiac catheterization laboratory, and an 18-bed operating room suite. Unit staff include a nurse manager, a unit-based educator, a

Eva M. Caruso, MSN, RN, is a Unit-Based Educator, Mayo Clinic Hospital, Phoenix, AZ.

clinical nurse specialist, a satellite pharmacy, a case manager, and a social worker. A unit-based practice team includes 12 staff RNs who are empowered by the nurse manager to implement unit-based changes in order to ensure best practices. The clinical environment in the 206-bed hospital is technology-based with cardiac telemetry monitoring capability available to all inpatient beds and a pocket paging system for RN telemetry notification in place of a monitor technician. In addition, nursing documentation occurs in an electronic medical record and all nurses carry a wireless telephone.

Prior to the implementation of the new nurse-to-nurse bedside report process, the offgoing nurse reported to the oncoming nurse in the nurses' station located in the central part of each pod. Patients were not involved in the report process and nurses were not guided by what content to include in the report.

Introduction to Nurse-to-Nurse Bedside Report

The initial interest for nurse-to-nurse bedside report arose when the author and the unit team leader attended a presentation during an event sponsored by the Arizona Nurses Association (AzNA). The presenters shared their experience in implementing nurse-to-nurse bedside report on a telemetry unit in a local acute care hospital. The similarities in hospital size and unit constitution as well as patient population further highlighted interest for the project. The presenters at the AzNA conference graciously agreed to host a site visit to enable the author to evaluate the report process in a clinical setting and to communicate with the staff nurses about their role. The site visit was both informative and encouraging; the decision was made by the unit manager, along with the unit-based educator and the unit team leader, to investigate the feasibility of implementing nurse-to-nurse bedside report on the medical/surgical cardiology unit.

The process of change is complex and usually filled with

Figure 1.
Stages of Change

Unfreezing Stage Objectives

To recognize the need for change. To build trust. To encourage participation.

Interventions

- Presented concept to staff RNs
- Promoted dialogue among staff RNs
- Addressed RN concerns
- Recruited interested staff RNs

Moving Stage Objectives

To plan the change. To initiate the change. To revise the process based on feedback.

Interventions

- Created a reporting template
- Created the report process
- Created an implementation plan
- Assisted and monitored the implementation process
- Collected feedback from staff RNs
- Revised process based on feedback

Refreezing Stage Objective

To integrate the change into practice.

Interventions

- Identify stage of change RNs are in and mentor accordingly
- Provide ongoing reminders of the process
- Incorporate reporting process into related clinical education

Source: Lewin, 1951.

challenges. To guide the change process, a conceptual framework was needed. Lewin's change theory was used to guide the change from an already-established practice of report in the nurses' station to report at the patient's bedside. A summary of the change process as it relates to the implementation of nurse-to-nurse bedside report is illustrated in Figure 1. Lewin (1951) identified three main stages in the change process. *Unfreezing* is characterized by recognizing the need for a change. *Moving* identifies the time when implementation of new processes occurs. *Refreezing* occurs when the change has been implemented and is now a firm part of practice. These stages guided the implementation of

nurse-to-nurse bedside report, giving the implementation team insight into the change process and the ability to anticipate potential challenges.

A Review of the Literature

Prior to implementing the change in report process, a review of the literature was conducted to examine different approaches to report, or handoff. Bourne (2000) identified three client-centered positive outcomes associated with nurse-to-nurse bedside report: (a) patient empowerment, (b) patient involvement, and (c) patient becoming an additional resource in diagnosis and treatment. A study conducted by Cahill (1998) described patients' perceptions of bedside report using a

grounded theory approach. The 10 study participants expressed an increased desire to be part of bedside report processes as their physical condition improved. Patients also believed that bedside report ensured a safe and professional transition of patient care from one nurse to the next. In addition, several patients recognized the value of their participation in promoting patient safety and identified the bedside report process as an opportunity for the patient to correct misconceptions.

Evidence exists in the literature that nurse-to-nurse bedside report promotes the nurse-patient relationship. In an investigation led by Kelly (2005), nurses reported an increase in the rapport between nurses and patients following the implementation of bedside report. A qualitative study conducted by Minick (1995) identified the concept of "making the connection" with a patient (p. 307). She described this concept as one that highlights the relationship between knowledge and caring. In her study, the researcher explored the processes used by critical care nurses in the early recognition of patient problems. She maintained that early recognition of patient problems occurred in the presence of caring behaviors.

On an organizational level, institutions are highly motivated to comply with the JCAHO standards in the 2006 NPSGs. The first goal requires facilities to "improve the accuracy of patient identification" (JCAHO, 2005), with a recommendation to use at least two patient identifiers. Nurse-to-nurse bedside report presents a clinically relevant opportunity for two nurses to verify the patient's identity using two means of identification. The second goal requires all organizations to "improve the effectiveness of communication among caregivers" and goal 13 instructs organizations to "encourage the active involvement of patients and their families in the patient's own care as a patient safety strategy" (JCAHO, 2005). These goals are central to the nurse-to-nurse bedside report process.

Recognizing the Need for Change: The Unfreezing Stage

Initial meetings with all 75 staff nurses had three objectives: (a) introduce the concept of nurse-to-nurse bedside report, (b) hear staff nurse concerns related to nurse-to-nurse bedside report, and (c) recruit nurses interested in participating in the implementation process of this pilot project. After a formal presentation, the common concern voiced by the staff nurses was that the bedside report process would take longer than the 30 minutes currently allocated for shift report. Nurses were reassured that based on information gathered during the site visit, nurses currently using this reporting process consistently report finishing work on time, or in some instances, early. Several nurses reported having had previous experience with nurse-to-nurse bedside report. Three nurses reported having participated in bedside report while practicing nursing in the Philippines. All of them confirmed the beliefs that conducting report at the bedside promoted patient safety and communication among caregivers. Other nurses had used the bedside reporting process in smaller rural hospitals where resources were limited. They also reiterated the benefits of including the patient in the reporting process. Five staff nurses, three of whom were members of the unit-based quality subcommittee, volunteered to be part of the implementation group. The unit-based quality subcommittee members chose to participate in the pilot project because any practice change could affect the quality of care. The implementation group consisted of seven nurses, including the nurse manager and the author.

Planning and Implementing Change: The Moving Stage

During the first meeting with the implementation group, a template of information to include during report was created to ensure a consistent report format (see Figure 2). Initially the template was to be completed by the nurse at the end of the shift and passed to the oncoming nurse. Nursing staff currently completed

individual report sheets and expressed the opinion that using an additional form was redundant and time consuming. The implementation group members believed a report template was critical to ensure safe, effective, consistent communication. They decided to keep the template and ask the nurses to follow this format for report without completing an additional form. The report template was laminated and given to all nurses as well as posted at the patients' bedside to allow for easy access during report.

Next, the implementation group established the new report process. After receiving the assignment, the oncoming nurse would locate the offgoing nurse and both would go to the patient's bedside, where the offgoing nurse would introduce the patient to the new nurse. Two patient identifiers would be used. Using the report template, the nurses would review the patient's history pertinent to this hospitalization and the reason for current admission, along with treatments and procedures. Assessments would be communicated and incisions, IV sites, tube insertion sites, IV infusion rates, and IV medication drip rates would be visualized and verified by both nurses. The patient could ask questions about the plan of care and dialogue about upcoming tests or responses to treatments.

Patient confidentiality was a concern of the implementation group. All rooms in the institution are private rooms; nurses would be instructed to close the door to the patient's room before initiating bedside report. In addition, the nurse would discuss the bedside report process with the patient upon admission to the hospital. The patient would choose whether the family or significant other could be present during bedside report, and those wishes would be passed from nurse to nurse. Toward the end of each shift, the nurse would remind the patient of the upcoming bedside report. To minimize interruptions by the patient during the report, the nurse would use this time to address the need for pain medication, toileting, and

Figure 2.
Bedside Report

Room:					
Patient Label:	Age:				
Diagnosis:	Alerts/Precautions:				
Code Status:	Hx pertinent to diagnosis:				
Allergies:	Procedure:				
MD:	Consults:				
VS:					
Neuro:	Ambulation:				
Lungs:	Chest Tube:				
O ₂ :	IS:				
Cardiac/Tele:	Edema:				
Pulses:					
GI/Abdomen:	Diet:	Last BM:			
Tubes:					
GU/Urology:	Foley/Void:				
Skin/Dressings:					
Pain:					
Intervention:					
Social/Psych:	Family Support:				
IV site:	IVF:				
Labs:	Tests:				
Disch/Plan:					
<input type="checkbox"/> Prep pt <input type="checkbox"/> Bed <input type="checkbox"/> Bath <input type="checkbox"/> Prn Meds <input type="checkbox"/> Toilet <input type="checkbox"/> Room prep					

Source: Mayo Foundation for Medical Education and Research, 2004.

other patient requests. A sign was created and displayed in each patient room stating, "Ask your nurse about bedside report." The intent was to remind patients as well as nurses about the new reporting process. Preparing the patient for the upcoming report proved to be a vital component of the implementation process and ultimately the success of the project.

During subsequent meetings, the implementation group identified the moving stage (Welch, 1979) as a critical time to support

the staff and be available for questions and assistance as well as ensuring compliance by all staff nurses. The seven-member group would share responsibility for monitoring the report process in person at each shift change for 6 weeks following implementation. Members of the implementation group would arrive 1.5 hours before shift change to make rounds and to assist nurses to prepare their patients and the environment for the upcoming bedside report. To promote change in the moving stage, the implemen-

tation group also would guide nurses to the bedside if old report habits took over.

A second meeting was scheduled with all staff nurses. The purposes of this meeting were to (a) promote unfreezing by reinforcing opportunities gained through use of bedside report; (b) inform the nurses of the implementation date; (c) introduce the report sheet; (d) introduce the bedside report process; (e) announce the assistance of the implementation group at each shift change during the first several weeks of the pilot

project; (f) role play the bedside report process; and (g) distribute clipboards and pens as a symbol of the initiation of the new report process. The role play was conducted by three staff nurses from the implementation group. The scenario illustrated two nurses and the patient engaged in bedside report, and it highlighted concerns such as time management and communication.

Monitoring and Integrating The Change into Practice: The Refreezing Stage

One month after implementation, all staff nurses were invited to a meeting to discuss nurse-to-nurse bedside report on the unit. Comments from nurses, patients, and their families were discussed. Nurses expressed uneasiness when talking in front of patients. They reported difficulty including the patient while at the same time managing the information needed for report and keeping to the allotted time. To the staff nurses' surprise, they described that report took an average 5-7 minutes, which was less than prior to the change. Several nurses informed the group of having identified infiltrated IVs, IV infusions low on fluid, and chest tube drainage devices needing repositioning during the nurse-to-nurse bedside report. Nurses also reported great satisfaction in having seen and briefly assessed the patient prior to initiating their shift. Comments by patients and their significant others, as reported by the nurses, were equally positive. Patients appreciated having met their nurse at the beginning of the shift, and the patients and their significant others were grateful to know the plan of care.

To address the concern expressed by the staff nurses regarding communication, a subsequent mandatory meeting was organized by the nurse manager and the author. Two staff nurses most comfortable and effective with the new report process were asked to speak about how they communicate with the patient and the nurse. They shared techniques on how to include the patient while limiting the dia-

logue to pertinent information only. Interestingly, these nurses who proved to be very effective communicators and bedside report champions were nurses who initially were opposed to the concept of bedside report.

During the moving stage of this project, the organization's leadership team learned of the implementation of bedside report and scheduled a meeting with the nursing staff to show their support. The leadership team members recognized that the change in practice promotes good patient outcomes and supports communication among caregivers while including the patient in his or her care, all which align with JCAHO standards and the NPSGs.

Outcomes and Evaluation

During an evaluation of the project months after implementation, inconsistencies were revealed regarding the compliance with bedside report by the staff nurses. Nurses reported frustration with the redundancy of having the patient listen to his or her history during every shift change. Nurses stated they liked report at the bedside but wished to modify the information to be included. The staff nurses' proposal was to continue with the communication, assessment, and plan of care at the patient's bedside. An initial report at the nurses' station would include patient history, past procedures, and confidential information prior to entering the patient's room.

The implementation group agreed to modify the report process with the suggested changes, although members expressed concern that the change may result in a move back to the old report process. They continued to monitor the report process during each change of shift to ensure that nurse-to-nurse bedside report remained a part of the nurses' practice.

Informal comments by patients also were reported. One patient shared that prior hospitalizations had left her feeling insecure and she was therefore fearful when anticipating her hospitalization. Her sister assured her that she

would stay with her during her hospital stay. When the patient experienced nurse-to-nurse bedside report, with both nurses checking her incision and discussing her plan of care, she reported feeling "in safe hands" and encouraged her sister to go home. Another patient commented, "I never knew nurses were so professional and organized." One patient referred to nurse-to-nurse bedside report as "the business meeting," and therefore he always made sure to be present during this "meeting."

Conclusion

The lesson learned while implementing nurse-to-nurse bedside report was that nurses view report as a "sacred cow," and the challenges when attempting to change this process can not be underestimated. Despite a unit culture of shared governance and motivation, and familiarity with change among staff nurses, consistent reminders and support with the bedside report process were required to arrive at the refreezing stage and to maintain this clinical practice.

Although nurses communicate extensively with their patients, it was surprising to the implementation team to learn that conducting report involving the patient was somehow perceived as difficult and uncomfortable for nurses. The reason for the uneasiness was identified by the nurses as a fear of having to interrupt the patient if the patient monopolized the report episode. One may speculate that the uneasiness is due to a lack of knowledge in effective communication techniques. Having staff nurses who felt comfortable communicating in the presence of and with the patients share their techniques appeared to be helpful to nurses who felt unsure of this process. Informing the patient of his or her role in the nurse-to-nurse bedside report process also was important in guiding patient participation and minimizing the disclosure of irrelevant information by the patient.

Although anecdotal reports from patients proved to be very

positive, some patients may not be as receptive to nurse-to-nurse bedside report. This phenomenon may depend on where the patient is in the disease process and what coping mechanisms are being used.

The primary intention of this project was to enhance patient safety by promoting nurse-patient and nurse-nurse communication. Patient safety and sense of security are of great importance to nurses in the medical-surgical setting, where patient acuity, technological innovations, and procedures place increased demand on their time and skill. The evolution of

nurse-to-nurse bedside report in this cardiology unit also promoted a sense of security and empowerment among patients. ■

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