Applied Nursing Research 40 (2018) 20–25

Contents lists available at ScienceDirect

Applied Nursing Research

journal homepage: www.elsevier.com/locate/apnr

Original article

Evaluation of bedside shift report: A research and evidence-based practice initiative

Victoria Schirm, PhD, RN[a,*], Geneva Banz, BSN, RN[b], Caitlin Swartz, BSN, RN[c], Marva Richmond, BSN, RN[a]

[a] Penn State Health M.S. Hershey Medical Center, Hershey, PA 17033, United States
[b] Penn State Health Medical Group, Hershey, PA 17033, United States
[c] Frederick Memorial Hospital, Frederick, MD 21701, United States

ARTICLE INFO

Keywords:
Bedside shift report
Evidence-based practice
Clinical nurses
Research

ABSTRACT

This evaluation of bedside shift report describes the process of involving clinical nurses in evidence-based practice (EBP) and research at an academic medical center by using existing structures and resources. Nurse involvement and study findings are described from idea inception to asking the clinical question, searching and synthesizing literature, collecting and analyzing data, interpreting results, and deriving conclusions. Study findings and conclusions demonstrate that nurses' active participation in a clinical relevant project promotes implementation and integration of EBP and research in the practice setting.

1. Introduction

Clinical nurse involvement in evidence-based practice (EBP) and research is an expected norm for providing safe, quality patient care and such participation is an expectation of organizations aspiring to achieve American Nurses Credentialing Center (American Nurses Credentialing Center Magnet Manual, 2014) Magnet® Recognition. The EBP and research directive stipulates that clinical nurses are to implement nursing interventions using best available evidence, conduct research, and disseminate findings. The ANCC mandate is echoed in Standard 13 of the American Nurses Association Scope and Standards of Practice (2015) that identifies EBP and research competencies for clinical nurses.

Supporting and documenting clinical nurses' involvement in EBP and research is a daunting task requiring support from organizational leadership (Stutzman et al., 2016). Day, Lindauer, Parks, and Scala (2017) recommended that financial outlays and commitment to EBP and research activities promote best practices. They also noted that shared governance council structures incorporating EBP and research functions create a synergistic effect that enhances clinical nurses' skill development and ability to complete projects. These and other successful programs of EBP and research (Mason, Lambton, & Fernandes, 2017) illustrate the structure, process, and resources needed to advance scholarly practice among clinical nurses. At the same time, findings from these initiatives suggest that continued efforts are needed to fully engage clinical nurses to embed clinical scholarship at the bedside.

This paper provides one organization's perspective in using existing structures and resources to showcase processes that engaged clinical nurses' in EBP and research. An investigation of bedside shift report (BSR) conducted at an academic Medical Center is used to describe clinical nurses' involvement in the scholarly process from idea inception to asking the clinical question, searching and synthesizing literature, collecting and analyzing data, interpreting results, and deriving conclusions.

2. Background

Nursing Research and Evidence Based Practice (NR&EBP) Council is responsible for integrating EBP and advancing nursing research. Clinical nurses with direct patient care responsibilities are majority members of Council. Selection and investigation of potential EBP and research projects is based on alignment with nursing's strategic plan. Selection is driven also by projects initiated by graduate nurses (GNs) in the nurse residency program (American Association of Colleges of Nursing, 2017). GNs are required to conduct an EBP project that is congruent with nurse sensitive indicators and organizational goals. Nurse managers, advanced practice nurses, and nurse educators guide GNs throughout the process that culminates with a formal presentation to nursing leaders.

* Corresponding author at: 1181 Chestnut Ridge Drive, State College, PA 16803, United States.
E-mail addresses: vmschirm@aol.com (V. Schirm), gbanz@pennstatehealth.psu.edu (G. Banz), cswartz@fmh.org (C. Swartz), mrichmond@pennstatehealth.psu.edu (M. Richmond).

https://doi.org/10.1016/j.apnr.2017.12.004
Received 13 March 2017; Received in revised form 2 November 2017; Accepted 14 December 2017

2.1. Supporting scientific inquiry in nursing practice

The Institutional Review Board (IRB) protocol for human subject research was the starting point and served as a template for guiding NR&EBP Council through steps of a research study. The final approved IRB protocol served as the one constant throughout the several changes that occurred during the project. The written protocol kept new research team members focused as Council membership fluctuated. Participants were continually reminded of intervening factors that created obstacles in conducting scientific inquiry in clinical settings. Debates occurred about the project's suitability as a quality improvement initiative versus a research investigation. A doctoral prepared nurse researcher and council facilitator (author VS), the council chair a research nurse coordinator, and the College of Medicine library liaison provided expertise and kept the group on track.

2.2. Literature review for best available evidence

The population, intervention, comparison, and outcome (PICO) question guided the team in the literature review: What are the components of BSR implemented by nursing units that report successful outcomes for patients and nurses? The library liaison conducted the literature search and provided links to articles. Frequently used terms for BSR were searched including nurse change of shift report, handoff, or handover.

The Joint Commission (JC) affirmed the process of transferring patient care between nurses as an expectation of safe quality care in the patient safety goal on communication among caregivers (Agency for Healthcare Research and Quality, 2016). The JC noted that handoffs should meet expectations of uninterrupted time to give and receive patient information and provide opportunity to verify and ask questions regarding the patient's plan of care. Vines, Dupler, Van Son, and Guido (2014) affirmed the JC requirement to “implement a standardized approach to handoff communications” noting that BSR is beneficial for both nurses and patients. They concluded that BSR encourages heightened awareness and accountability among nurses to involve patients in care decisions.

Although evidence supports favorable outcomes with BSR, implementation sometimes meets with resistance by nurses that perceive BSR an inefficient means of communication, a cause of delays in patient care, and a source of stress (Sand-Jecklin & Sherman, 2013). Patients also reported disadvantages of BSR such as repetition in hearing the same report over several shifts (Jeffs et al., 2014). Others found that BSR requires considerable effort to implement and sustain long term (Gregory, Tan, Tilrico, Edwardson, & Gamm, 2014; Sand-Jecklin & Sherman, 2014; Wakefield, Ragan, Brandt, & Tregnago, 2012). Tobiano, Chaboyer, and McMurray (2012) advised that nurses need education to effectively implement family centered BSR and Salani (2015) cautioned that BSR implementation requires changing nursing behaviors. Findings of Sand-Jecklin and Sherman's (2014) quasi-experimental investigation suggested that positive outcomes of increased patient satisfaction with nursing care and nurse accountability may encourage ongoing implementation of BSR. The process also may require a standardized change management strategy to enhance compliance (Scheidenhelm & Reitz, 2017).

In summary, this literature captures elements of BSR implementation in other settings and describes outcomes experienced by nurses and patients. The findings provided evidence for NR&EBP Council's study of BSR and provided background for the IRB approved protocol. As these events were taking place, the Chief Nursing Officer requested that nurse managers implement BSR as a best practice. This directive caused the research team to reconsider the direction of the original protocol and focus on a real-time evaluation of BSR implementation.

2.3. Purpose

The primary purpose of the study was to evaluate nurses' perceptions regarding BSR as it was being implemented at the Medical Center. A secondary purpose was to assess indirectly patient satisfaction with BSR using publicly reported measures of satisfaction with nursing care.

3. Methods

3.1. Procedures

Nurses' perceptions of BSR were evaluated via a 17-item Nursing Assessment of Shift Report (Sand-Jecklin & Sherman, 2013). Items include communication effectiveness and efficiency, ability to identify patient safety and status changes, access to information, and opportunity for patient participation. Two items from the original were omitted: the item on “mentoring and teaching of newer nursing staff” did not request information that was relevant to the current study and the item “I feel adequately informed about all aspects of care for my assigned patients” was considered redundant of “I feel adequately informed about the plan of care for my assigned patients.” Respondents rate each item using a 5-point Likert scale of 1, strongly disagree to 5, strongly agree. Sand-Jecklin and Sherman reported a reliability of 0.90, with item correlations ranging from 0.20 to 0.71.

Patient satisfaction with nursing care, measured by National Research Corporation (National Research Corporation, n.d.) survey items, evaluated indirectly patients' perceptions of BSR. NRC items are consistent with Hospital Consumer Assessment of Healthcare Providers and Systems data. Three items based on work by Reinbeck and Fitzsimons (2013) were selected: During this hospital stay how often did nurses (a) treat you with courtesy and respect, (b) listen carefully to you, and (c) explain things in a way you could understand. Two additional NRC items were included: During this hospital stay (a) how often were you able to discuss your worries or concerns with nurses and (b) how often did you have confidence and trust in the nurses treating you?

3.2. Measurement and data analysis

Descriptive statistics are reported for sample characteristics and responses to the adapted 15-item Assessment of Shift Report questionnaire. Nurses' perceptions of BSR were categorized into two groups: agree/strongly agree and strongly disagree/disagree (included neutral responses). Chi square tests determined significance between agreement and disagreement for each of the 15 items. Two sample *t*-tests compared patients' perceptions of nursing care on NRC survey items for fiscal years ending June 30, 2015 to responses on the items for June 30, 2016.

Content analysis conducted by the authors used previous studies (Johnson & Cowin, 2013; Sherman, Sand-Jecklin, & Johnson, 2013; Tobiano et al., 2012) as guidance in identifying themes from nurses' responses to open ended questions. Analysis considered What is being said? What seems to be going on? What does it mean? What are similarities? What are differences? Nurses' responses were grouped by nursing areas: Acute Care, Critical Care, Children's Hospital and Women's Health, Nursing Float Pool, and a miscellaneous category that included responses from adult and children's perianesthesia units or where a specific nursing unit was not identified.

4. Results

4.1. Response rate and nursing characteristics

A SurveyMonkey Inc. (2016) link for the 15-item questionnaire and 3 open ended questions was sent to 2705 nurses between September 21, 2015 and November 16, 2015. Although 791 nurses opened the survey for a response rate of 29%, not everyone continued on to complete the