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On the Same Page: Nurse, Patient, and Family Perceptions of Change-of-shift Bedside Report

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ABSTRACT

Purpose: The purpose of this study was to explore nurse, patient, and family perceptions about change-of-shift bedside report in the pediatric setting and to describe specific safety concerns that were identified during change-of-shift handoff.
Design and Methods: An exploratory-descriptive qualitative study designed to elicit nurse, patient, and family experience with change-of-shift bedside report was utilized for this study. Interviews were conducted and reviewed to identify common themes.
Results: Data analysis revealed the emergence of the following themes: perceived barriers, patient safety, and impact on patient care. Study participants found that bedside report promotes patient safety and is the preferred form of change-of-shift handoff communication. Additionally, participants stated there is increased accountability and increased transparency as everyone involved in bedside report is "on the same page."
Conclusion: The study results are consistent with current literature suggesting that bedside report contributes to effective communication and increases patient safety.

Recent studies suggest that as many as 80% of medical errors are attributed to ineffective communication (The Joint Commission, 2012). Nursing change of shift hand-off report has been specifically associated with preventable errors including sentinel events (Agency for Healthcare Research and Quality, 2012; The Joint Commission, 2012). In 2012, The Joint Commission and the Institute for Patient-and Family-Centered Care recognized the presence of patients and families during the change of shift handoff report as an important safety measure to promote collaboration and enhance communication. Despite recommendations to incorporate patients and families in bedside report, there are few studies that examine the impact of bedside report on patient safety and a lack of literature on the use of bedside report in the pediatric setting. The purpose of this study was to explore nurse, patient, and family perceptions about change-of-shift bedside report in the pediatric setting and identify specific safety concerns that are recognized during change-of-shift handoff communication.

Background

Effective handoff communication is essential to optimizing the delivery of safe patient care (Cairns, Hoffmann, Dudjak, & Lorenz, 2013; Caruso, 2007; Friesen, Herbst, Turner, Speroni, & Robinson, 2013; Griffin, 2010; Jeffs et al., 2014; Popovich, 2011; Riesenberg, Leitzch, & Cunningham, 2010). Change-of-shift report is particularly important as it involves the exchange of patient information and the transfer of responsibility of care from one nurse to another (Caruso, 2007; Riesenberg et al., 2010). Change-of-shift report is intended to aid in the continuity of care, support the exchange of patient information, include opportunities to seek clarification, and promote patient safety (Caruso, 2007; Riesenberg et al., 2010). Due to their psychological differences, limited understanding of the healthcare process, and their inability to advocate for themselves, pediatric patients are especially vulnerable to errors associated with ineffective communication during change-of-shift report (Popovich, 2011).

According to a study conducted by the Agency for Healthcare Research and Quality (2012), nearly 53% of surveyed healthcare professionals claim that valuable information is lost during handoff reporting. Information omitted during change-of-shift handoff reporting is often vital for the continuity of nursing care and promotion of patient safety. Ineffective communication has been associated with delays in treatment, omission of care, readmissions, and adverse and sentinel events (The Joint Commission Center for Transforming Healthcare, 2013). These incidents cost billions of dollars per year and with current reimbursement processes, healthcare organizations are now acquiring the cost of such errors. With this understanding, it is vital for healthcare organizations to facilitate effective communication and reduce errors.

To improve the communication process that specifically occurs during nursing change-of-shift, The Joint Commission (2012) recommends

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the implementation of a standardized handoff reporting process. The Joint Commission Center for Transforming Healthcare (2013) created specific guidelines to improve the communication that occurs during handoff reporting. The guidelines include creating a scripted verbal handoff report and involving the patient and family. Incorporating the use of technology, such as a patient's electronic medical record, is also recommended to facilitate the accurate exchange of real-time patient information (Friesen et al., 2013; The Joint Commission Center for Transforming Healthcare, 2013). Additionally, patient safety checks are often integrated into the change-of-shift handoff process (Baker, 2010; Popovich, 2011).

Patient and family presence during the entire change-of-shift handoff reporting process is highly recommended (Joint Commission Center for Transforming Healthcare, 2013). Both The Joint Commission (2012) and the Institute for Patient-and Family-Centered Care (2012) consider the presence of patients and families during change-of-shift handoff report an essential safety measure as it promotes collaboration and further enhances effective communication. Active patient and family participation has been shown to result in better healthcare outcomes as patients become motivated to participate in the recommended plan of care (Anderson & Mangino, 2006; Cairns et al., 2013). Recent studies conducted in the adult and geriatric populations, have confirmed that patient and family presence during change-of-shift handoff report improves the collaboration between the patient, family, and healthcare team (Anderson & Mangino, 2006; Athwal, Fields, & Wagnell, 2009; Tidwell et al., 2011). Patient and family engagement scores as well as nurse sensitive indicators have demonstrated sustained improvement with patient and family presence during bedside report (Anderson & Mangino, 2006; Cairns et al., 2013; Jeffs et al., 2013; Maxson, Derby, Wrobleski, & Foss, 2012; Sherman, Sand-Jecklin, & Johnson, 2013). From such findings, it is evident that patient and family inclusion during change-of-shift handoff report creates a collaborative environment.

A vast majority of the studies relating to change-of-shift bedside report have been conducted on the adult population (Popovich, 2011). Very few bedside report studies have been conducted in a pediatric setting, and even fewer examine the impact bedside report has on patient safety (Jeffs et al., 2013; Maxson et al., 2012; Popovich, 2011). As a result, there is limited understanding of what makes bedside report a safer form of handoff communication when compared to other methods of handoff communication.

Methods

This study uses an exploratory-descriptive qualitative strategy to elicit nurse and patient/family experiences with change-of-shift bedside report. The study was proposed and conducted at a freestanding children's hospital in Southern California. Following institutional review board approval, the study was conducted in the medical and surgical units. The medical unit has 48 patient beds with an average daily census of 34 patients, and the surgical unit has 34 patient beds with an average daily census of 17 patients.

It was the expectation that the nurses on both units conduct bedside report at every change-of-shift. In 2012, nurses received comprehensive education and training resulting in bedside report becoming standard practice. The bedside report process incorporated the use of a standardized report process, electronic medical record, patient and family involvement, and a safety check.

Over a six-month period (April 2015 through September 2015), a convenience sample of nurses, patients, and families was recruited from the medical and surgical units. Informational flyers and e-mails requesting participation were provided to the medical and surgical nurses (approximately 120 nurses) on both day and night shift. Participating nurses were full-time and part-time employees who had worked for a minimum of 12 months on either unit with varying years of nursing experience (two to 20 years).

An informational flyer was also provided to all patients and families admitted to either floor for a minimum of one day. Approximately 25 patients and families were approached to participate. The patient and family participants were selected after checking in with the charge nurse and inquiring on which patients and families were available. Inquiries with the charge nurse occurred on both day and night shift. A total of five interviews were conducted during the day and ten were conducted during the night, totaling 15 patient and family interviews. Of the 25 patients and families approached, four declined to participate and six were unable to participate due to lack of availability.

English and Spanish speaking patients and family members were included in this study. Non-verbal patients, patients with developmental delays, patients under ten years of age, and patients without a parent/guardian to consent participation were excluded. Study participants included 25 nurses (12 from the medical unit and 13 from the surgical unit) and 15 patient and family (nine patients and six family members). Consents and, as necessary, assents were collected.

The principal investigators, using two semi-structured interview guides (one for the nurses and one for the patients and families), interviewed all study participants (Fig. 1 & Fig. 2). The goal for both guides was to explore nurse and patient/family perceptions about change-of-shift bedside report, patient safety, and quality of care. Various studies were reviewed to develop interview questions that would elicit the desired perceptions from participants (Anderson & Mangino, 2006; Friesen et al., 2013; Jeffs et al., 2013; Jeffs et al., 2014).

All interviews were tape-recorded and transcribed using Verbal Ink. Interviews in Spanish were conducted and translated with the help of translator services. Study participants received a five-dollar gift card for their participation. The principal investigators and three additional nurse colleagues analyzed and reviewed the transcribed interviews for common themes.

Results

Saturation of data was reached with 25 nurse and 15 patient and family interviews (40 total interviews). Participants were asked a series of multiple choice and open-ended questions. Of the open-ended questions, the participants identified the following three themes: barriers to conducting bedside report, patient safety, and impact on patient care. Similarities and differences were identified in the responses provided by the nurses, patients, and families.

Perceived Bedside Report Barriers: Nurses

Nurse participants identified several barriers to conducting bedside report. The most commonly described barrier was that bedside report is time-consuming. Another barrier frequently discussed by nurses is the belief that patients and families do not want to be bothered. When asked about barriers to educating patients and families about bedside report, most nurses responded that there is too much information to provide; thus, bedside report was often left out during orientation. Additionally, some nurses stated that they simply forgot to provide bedside report education to patients and families.

Perceived Bedside Report Barriers: Patients/Families

The patient and family participants did not express any perceptions of barriers. When asked if they received education about bedside report during their hospital stay, 46% percent of the participants indicated that they were educated on bedside report. Only 21% stated that they understood their actual role in the bedside report process. Furthermore, 14% reported that fatigue played a factor in understanding bedside report and the role in which they play during the report process.

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