Addressing Perceptions of Bedside Reporting for Successful Adoption

JoAnn A. Frazier, BSN, RN, CPHQ, and Wes Garrison, MSN, MBA, RN, NE-BC

With the changing healthcare climate, healthcare organizations are increasing their focus on delivering high-quality care and improving patient safety.[1] One nursing practice that is getting heightened attention is the practice of bedside reporting (BSR) as the preferred means of end-of-shift handoff communication. Extensive literature supports the practice of bedside reporting as a means of improving quality care, patient satisfaction, and patient–family participation in the plan of care.[2,3] Additionally, BSR can increase communication and accountability between nurses, improve communication between the nurse and patient, improve coordination of patient care, and increase patient–family adherence with the plan of care.[4]

THE NEED FOR CHANGE

St. Vincent Infirmary Medical Center (SVI) is part of St. Vincent Health System in Little Rock, Arkansas, which comprises 3 hospitals and 8 clinics. The health system is a member of Catholic Health Initiatives, a national nonprofit healthcare organization. In January 2013, the American Nurses Credentialing Center (ANCC) recognized St. Vincent Infirmary as a Magnet® organization.

In the spring of 2011, managers of 4 nursing units at SVI identified similar challenges on their units: patients/families not involved in the plan of care, lengthy shift report resulting in unnecessary overtime, and a general lack of communication among the nursing staff. Each of the managers had prior experience with BSR at other organizations, and each thought that implementing the practice on their units could address those challenges successfully. A senior nurse leader assisted in collaborating with the managers, and an idea to pilot a BSR initiative to improve communication was developed. However, to move forward with the project, it was necessary to understand a vital piece of historical fact: SVI previously implemented BSR in 2009, but failed to sustain the practice long term.

To understand the previous failure and to successfully adopt BSR, the team needed to understand staff perceptions and the barriers to changing those perceptions. Feedback from direct care staff was elicited, and common themes emerged as to why this practice was unsuccessful in previous attempts:

- No clear communication for *why* the practice change was necessary
- No education about *how* to perform the practice
- Lack of *communication* to staff about how the practice change was improving patient care
- No *staff accountability* to implement the practice
- Lack of practice *validation* post-implementation

A PILOT INITIATIVE WAS DEVELOPED

The pilot team members utilized the feedback about past failures to establish a plan to pilot BSR on the 4 nursing units: 3 surgical and 1 medical. Upon receiving support from the senior nursing leadership, the 3-month pilot plan was formalized and rolled out. The pilot was structured around the obvious theme in the failure of past attempts: communication.

The pilot team used a tool: survey registered nurse (RN) staff to obtain baseline data about common perceptions and misconceptions about bedside reporting. After the survey was complete, informal education in the form of articles from literature review was provided to staff, supporting BSR as a practice change. A formal education module was developed, communicating not only the reasons for implementing the pilot, but also a summary of the evidence-based literature supporting the practice. Explanation of the steps involved in performing the BSR practice was clearly communicated to the pilot units. The team also took into account that visual aids could be a helpful learning tool in adult learning, and the team produced a video that would be used in conjunction with the formal training component. Because 1 of the misconceptions of BSR was that it would take longer than traditional report formats, the pilot training video included a timer in the bottom of the screen demonstrating to the viewer that a comprehensive, real-time end-of-shift report could be given in approximately 5 minutes per patient. Once education was complete, each staff RN received competency assessment verification via a formal check-off tool.

SUPPORTING/MONITORING A CHANGE IN PRACTICE

From the inception of the idea to change practice, the unit managers made a clear case for the need for change and the expectations for the outcomes. All managers had previous experience with the BSR practice in other organizations and had seen the benefits of the practice on the patients and on the organizations. Those experiences helped them to effectively lead their units through the transition process.

Once the pilot began, daily patient rounding by the nurse manager elicited individual patient feedback that the managers could (in real time) take back to the staff in order to bolster staff support, as well as coach staff who were not following the BSR process as instructed. Additionally, results from periodic rounding by the off-shift supervisors and "mystery shopper" audits were given to the managers, allowing validation that staff were adhering to the BSR process in order to hold staff accountable to implementing the practice. Weekly review of patient satisfaction metrics were shared with the unit staff, as well as a pilot dashboard of specific metrics that were most impacted by the BSR practice change.

OUTCOMES

The staff perceptions regarding the practice of BSR were resurveyed 3 months post-implementation of the pilot. Using a 5-point Likert scale, results showed improvement in 5 of the 6 metrics (*Figure 1*). Staff responses regarding the BSR practice were mostly positive, including many nurses verbalizing an improvement in their ability to prioritize their workload at the beginning of their shift and a clearer understanding of the patient condition, as they could immediately confirm accuracy of the verbal report with the clinical picture. "Bedside reporting gives me a great start to my day," reported one nurse. The RN staff of the pilot units also provided feedback that allowed the team to understand ongoing concerns that needed to be addressed in order to successfully sustain the practice change. These concerns and potential barriers to adoption included:

- Violating patient privacy when visitors were present
- The nurse who resists the BSR practice
- Patient/family requests to not perform report at bedside
- The sleeping patient
- The sleeping patient with various pain issues during the previous shift

The team determined appropriate responses to the special situations that the staff identified and re-produced the training video to incorporate staff feedback. Although there were many nurses who readily adopted the practice change, there was push-back noted from others who were not as ready to change their practice or were not as proficient in the reporting format. The