



AMERICAN UNIVERSITY OF BEIRUT

Bedside Report: A Patient-Centered Approach to Intershift  
Handoffs

by  
MOHAMMAD ABBASS

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submitted in partial fulfillment of the requirements  
for the degree of Master of Science in Nursing  
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AMERICAN UNIVERSITY OF BEIRUT

BEDSIDE REPORT: A PATIENT-CENTERED  
APPROACH TO INTERSHIFT HANDOFF

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MOHAMMAD AHMAD ABBAS

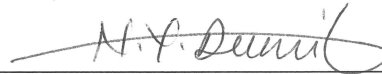
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## AN ABSTRACT OF THE PROJECT OF

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In 2007 Joint Commission did a root cause analysis of sentinel events and showed that passing inaccurate information and incomplete information between nurses will lead to very serious sentinel events. Concerns were raised by nurses on a medical-surgical unit at American University of Beirut about the current problems with the inter-shift report such as: missing information, noise, a lot of interruptions and chaotic environment where report is given. The aim of this project is to propose a new handoff reporting method, one that standardizes procedures and provides patients and their families the opportunity to participate in the handoff process. Bedside Intershift report is a process that focuses on involving patients in their daily plan of care at the beginning of every shift. The transition plan is guided by Lewin's Change Model: Unfreezing, Change and Refreezing.

Four nurses participated in the piloting process in a medical-surgical unit at AUBMC. It took one minute for patient with acuity III, two minutes for patient with acuity IV and three minutes for patient with acuity V. Three main challenges faced during piloting phase were: violation patient confidentiality, functional care model at night and sleeping patients. To have a smoother change, it recommended to have a gradual implementation, extensive training, continuous monitoring and leaders' support as means to sustain and integrate the change.

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# CHAPTER I

## INTRODUCTION

Nurses take care of patients 24 hours a day, which implies sharing information among nurses between shifts to ensure the continuity of care. Information shared includes updates on patient condition and plan of care referred to as “intershift report”. During the process, nurses might get distracted and interrupted many times like answering phone calls, or patients’ intercom, and patients concerns; this will result in communication failure that negatively affects patients’ health (Cairns et al., 2013). Nursing leaders stress the importance of recognizing patient handoff communication not as a mere exchange of information, but rather a process that comprises transferring professional responsibility and accountability for all patient care aspects (Australian medical association, 2006). International guidelines recommend that for the handoff to be effective, verbal face-to-face communication should be used, along with a written standardized tool. Many hospitals tried to adopt these recommendations; yet, the implementation was challenging and the process includes a major safety concern worldwide.

### **A. Background and significance**

In 2009, the Joint commission on Accreditation of Healthcare Organization (JCAHO) mentioned that most sentinel events relate to handoff communication, and are due to missing information, inability to recall information, interruptions, noise while providing the report, and the absence of a standardized tool (Salani, 2015). In 2006, JCAHO added to its national patient safety goals one goal related to ensuring proper communication between caregivers; they stressed the importance of using a standardized tool, providing time for asking and responding to questions between incoming and outgoing nurses, and limiting interruptions during handoff report. In 2008, the joint commission introduced another patient safety goal

that stresses the importance of encouraging patients to get involved in their care (Joint Commission, 2008). This goal is in line with the patient-centered model emphasized by the Institute of Medicine as a mean to improve clinical outcomes and patient satisfaction (Lusk & Fater, 2013).

The IOM defines patient-centered care as “Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (IOM, 2010). Patient centered care focuses on four core concepts that are dignity and respect, information sharing, involvement and collaboration. Moreover, patient- centered care aides in assessing, identifying patient needs, disease prevention and continuity of care that eventually affect patient health positively. One approach that fulfills the core principles of patient centered care model is to follow a new strategy for conducting the intershift report, one that standardizes procedures and incorporates a bedside component.

## **B. The problem**

In a medical /surgical unit at AUBMC, intershift reports take place at the nurses’ station, which is a very small area. The incoming nurse and outgoing nurse perform a face-to-face intershift report without involving the patient or family in the process. The handoff communication policy at the American University of Beirut Medical Center (AUBMC) was using before GATE tool: “G” refers to general data as patient name, number etc...; “A” assessment, “T” treatments; and” E” evaluation (AUBMC Policies and Procedures, 2015). Recently they updated and recommended the following standardized tool called ‘I PASS’ Tool (Appendix A) (Starmer et al., 2012). The letter “I” refers to Illness severity as patient condition (Stable or Unstable); “P” refers to patient summary as history as chief complaint; “A” Action list as to do list; ” S” Situation awareness and contingency plan as to do plan for what might happen; and “S” Synthesis by receiver then the receiver will summarize and

restate all patient information. Nursing administration has chosen I PASS as an official handoff tool because it is more traceable for checking missing information during intershift report than GATE tool; this was one of Joint Commission requirements. During monthly staff meeting, concerns were raised by nurses about the current problems with the intershift report such as missing information, noise, many interruptions and inaccurate recall of information. One way to address this problem is to change from the current method of handoff to a standardized bedside handoff. Bedside intershift report is a process that focuses on involving patients in their daily plan of care at the beginning of every shift. During the process, the patient is given the chance to ask questions, to monitor the completeness and accuracy of information exchanged, and accordingly to participate in setting the plan of care (Anderson & Mangino, 2006).

The most significant component of a bedside handoff process is that it comprises a team approach (the oncoming nurse, the off going nurse, and the patient and his/her family if the patient requested so) to assessment, identification of needs, planning, and implementation of care. The presence of the patient in this team helps nurses validate their understanding of healthcare needs and concerns; at the same time, it empowers the patient to make informed decisions about his plan of care. The fact that the oncoming and the off going nurses exchange pertinent patient information in the patient' room will give them the chance to simultaneously assess and validate together his/her physical, emotional, and cognitive wellbeing; identified needs will be addressed on the spot, and together, they will perform an environmental safety check. In Lebanon there are few available studies related to handoff communication. A survey was conducted by El Jardali et al. (2010) to assess the current state of patient safety culture in Lebanese hospital. Sixty-eight hospitals participated in the study, the findings revealed that communication during hospital handoff is not adequate and is a major safety concern for nurses.

## CHAPTER II

### LITRERATURE REVIEW

The purpose of the literature review is to identify the impact of implementing bedside intershift report on nurses' satisfaction and patient outcomes. The articles reviewed involved measuring nurses and patient satisfaction after the implementation of bedside report. The majority of studies were conducted on medical/surgical units, and the trigger for change was the nurses' concerns about the inefficiency of traditional methods. In addition to nurses and patients' satisfaction, the outcomes measured in those studies were the accuracy of communication, duration of report and related time cost, and patient falls during the intershift report.

#### **A. Effects on Patients**

The studies that included measuring patient satisfaction post introducing the bedside intershift report revealed that patients were more satisfied because they were updated on their health status and were given the opportunity to discuss their plan of care (Anderson & Mangino, 2006; McMurray et al. ,2011; Maxson et al. 2012; Laws & Amato, 2010; Sand-Jecklin & Sherman, 2014). Involving patients' in their care positively affected their health status and compliance with medical regime which made the implementation of treatment easier (Caruso, 2007; Maxson et al, 2012). Moreover, patients felt more secure when they observe nurses working as a team (Caruso, 2007; Laws & Amato, 2010). One study identified a 33% decrease in patient call light usage during the intershift report (Cairns et al., 2013). A study by Sand-Jecklin & Sherman (2014) showed that patient fall was reduced at shift change after implementing the bedside report.

According to McMurray et al. (2011), involving patients in the handoff communication improved the quality of information exchange because patients were correcting inaccurate information during the process. A study conducted by Tobiano, Chaboyer and McMurray (2013) showed that when the patient and his/her family are involved in the handoff process, they were adding or clarifying issues related to the patient, thus facilitating the communication process between nurses. Furthermore, patients will no longer be referred to only in numbers (example patient 30, 31 etc...) and will be addressed by their names as handoff inside the patient's room will humanize him/her and force the nurses to see them as more than just numbers (Tobiano, Chaboyer, and McMurray, 2013).

## **B. Effect on Nurses**

The studies that included measuring nurses' satisfaction post introducing the bedside intershift report revealed that nurses were more satisfied because they noticed an increase in the accuracy of information exchanged (Anderson & Mangino, 2006; Sand-Jecklin & Sherman, 2013), as well as a more sense of accountability among nurses and better teamwork (Cairns et al., 2013; Chaboyer et al., 2009; Laws & Amato, 2010). Through implementing bedside report, it is easy to prioritize care and manage it effectively through assessing the high acuity patients, first thing during nurses round (Anderson & Mangino, 2006; Evans et al, 2012). Yet, most of the studies stressed the fact that the initial phase of introducing the change from traditional method to bedside method faced some resistance by nurses (Cairns et al., 2013; Tobiano, Chaboyer, and McMurray, 2013).

## **C. Effect on Time Management and Cost**

A study conducted by Cairns et al. (2013) revealed that bedside report saves around 100 hours of incidental overtime per year. Furthermore, most of the studies observing report time displayed that bedside report took a smaller amount of time (Anderson, & Mangino,

2006; Sand-Jecklin & Sherman, 2014; Wakefield, 2012;). According to Sand-Jecklin & Sherman (2014), the average time for bedside report per patient takes around 2 to 3 minutes. Tidwell et al. (2011) estimated an annual saving of around \$13000 when staff overtime decreased during bedside handoff.

#### **D. Purpose of the Project**

The aim of this project is to propose a new handoff reporting method, one that standardizes procedures and provides patients and their families the opportunity to participate in the handoff process. The project steps include:

- 1- Developing a training video and companion toolkit to educate nurses and patients on how to conduct a safe, effective and patient centered bedside handoff.
- 2- Getting the feedback from nurses regarding bedside handoff process during a medical-surgical staff meeting.
- 3- Piloting the bedside report project.
- 4- Providing recommendations.

## **CHAPTER 3**

### **METHODOLOGY**

The theoretical framework used to guide this change is Lewin's change theory (Kaminski, 2011) that comprises of three main phases: first, the unfreezing phase that aims at identifying the need for change, building trust, and encouraging participation; second, is the moving phase, during which the change is planned, initiated, and revised based on feedback sought; the Last phase includes integrating the change into practice. Activities and steps at every phase are described in the next sections.

#### **A. Unfreezing Phase**

The objectives of the unfreezing phase are to recognize the need for change, to build trust and to encourage participation. The concept of bedside handoff was introduced to nurses on a medical-surgical unit during a staff meeting after they expressed their concerns about the ineffectiveness of the current handoff process. At the beginning of the discussion, all nurses were supportive and optimistic with this new concept. But afterwards, they started to highlight some of the barriers that they might encounter such as time consuming and patient privacy. None of the nurses reported trying this type of intershift report before, four nurses of them showed interest to participate in the pilot phase. However, nurses agreed that a force field analysis exploring possible barriers and facilitators needs to be performed to identify whether this project is worth doing or not.

### **Force Field Analysis.**

Kurt Lewin developed the concept of force field analysis as a decision making techniques that helps in making decision by examining the forces for and against a change before making the decision. Each force is given a score from one (weak) to five (strong). Strong/enabling forces are those that support the change while weak/restraining forces are the ones that prevent the change (Lewin, 1951). A small group of nurses from medical-surgical unit gathered to review the literature findings about impact of bedside handoff on nurses' satisfaction and patient outcomes; to brainstorm possible barriers and facilitators to implementing bedside handoff at a medical-surgical unit; and to look at strategies proposed by the literature to mitigate identified barriers.

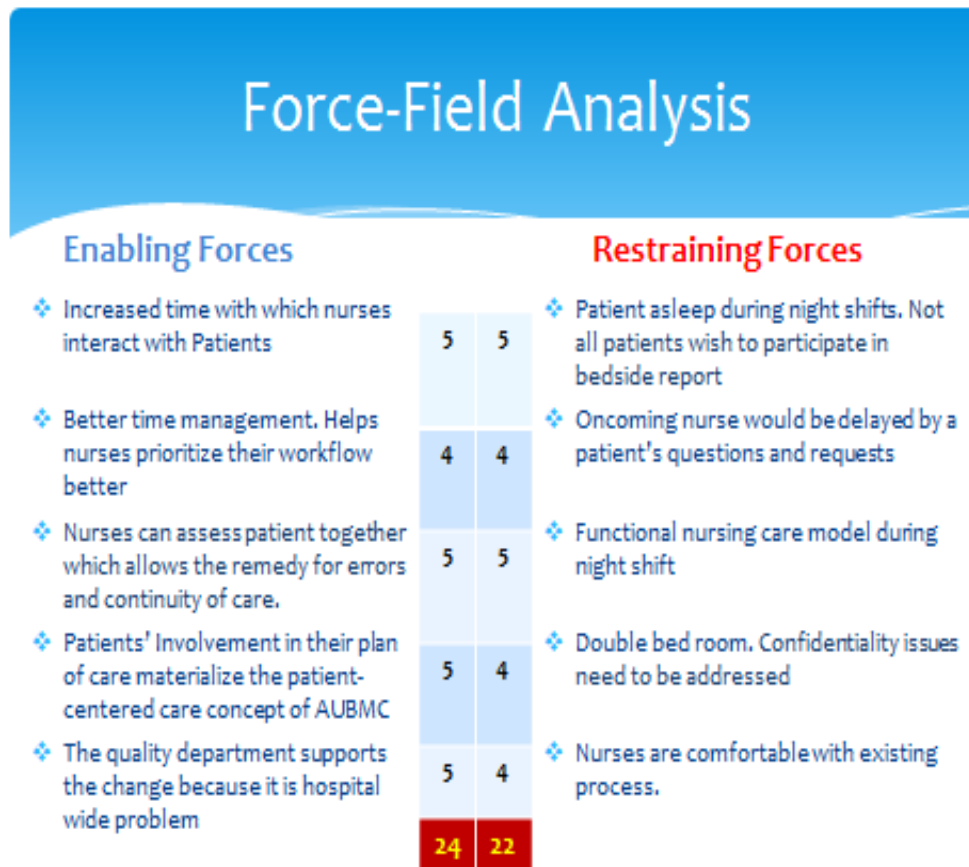
Based on the evidence from different studies reviewed, the driving forces were those that proved to improve patient safety and the quality of care through the following: (1) involving patients and families in the handoff will help them clarify, correct, or add any missing information during the process; (2) nurses will be able to prioritize their work better by identifying patients with urgent needs (3) double checking will be performed to assess

patient status and environmental safety; (4) nurse/patient quality time will be increased; (5) patients will be more involved in their plan of care and empowered to make informed decisions; and (6) bedside report will improve nurse-to-nurse communication, and increase nurses' accountability.

The restraining forces included the risk of disclosing patient confidential information in front of others (double bed room and visitors); inability to do the bedside report when patient is sleeping (especially in the night intershift report); the fact that during the night duty functional nursing care model is followed where nurses have more patients than their colleagues of the day and evening duty making handoff time consuming. During night shift, two nurses give the intershift report to five nurses so it will consume more time. Another concern reported by nurses was that during the report, patients might have so many questions or requests that will delay the report and consequently the off going nurse.

After allocating scores to every mentioned force (figure 1), the total score of enabling forces was 24, while that of the restraining forces was 22; the team decided that although the change might face considerable restraining forces, the benefits outweigh the constraints, and the change is worth to be piloted.





**Figure 1. Force-Field Analysis for Bedside Intershift Report**

## **B. Movement Phase**

The objectives of the movement phase are to plan the change, pilot the change and to revise the process based on feedback.

### **1. The tool**

The planning/movement phase started by deciding on the tool. The existing handoff tool at a medical-surgical unit is the GATE tool (AUBMC Policies and Procedures, 2015). However the nursing administration and the Clinical Professional Development Center started the piloting of I PASS tool. The tool is not a form that can be filled by nurses for every patient, it is rather considered as a guide to help nurses follow a standardized way of

exchanging patient information. It reminds nurses of important criteria that need to be conveyed during the intershift report. Moreover, the new handoff communication policy states that the tool should be used as a guide to write nursing notes. At the end of every shift, the leaving nurse will write the nursing note as per the I PASS format design and leave a space for the oncoming nurse to sign that she/he received a written summary of the verbal handoff.

## **2. The proposed change**

The steps of the new proposed bedside handoff include the following: at the end of each shift, the coming and leaving nurses will have a small information exchange outside the patient room. The information exchange includes exchanging confidential patient data such as new issues and abnormal patient assessment findings. Inside patient room, the leaving nurse will introduce the on-coming nurse to the patient and family members (if the patient wants the family members present). Both RNs will assess the pain level of the patient, review treatments and plan of the day. Moreover, they will conduct a patient safety check (ID band, incision, IV site, PCA settings, drains/Foley, fall risk); check the environment for safety (call bell, walker in reach, bed alarm); and ask the patient (and family) if they have anything to add or have questions.

One of the differences between the current and proposed handoff is that the current handoff communication process occurs at the nursing station between the off going and the oncoming nurses, without involving the patient or his/her family in the process. The main problems in this methodology are: the environment is very distractive (phone calls, call lights, many people around...); the content of the exchanged communication is not structured; and the nurses' report about patient status as remembered. These factors make nurses prone to give inaccurate and/or incomplete information. The proposed change targets changing the environment, so nurses will enter patient room and close the door to be able to

focus on the patient and his/her needs only. The tool will be used as a guide to help them focus on pertinent information to be conveyed; moreover, the patient will be there to correct or add any missing information about his/her needs and concerns (figure 2).

	Current process	Proposed change
Handoff method	Face to Face	Face to Face & Written
Context	Nurse station	Bedside
Information exchange tool	Patient file, GATE tool	Patient file, IPASS tool
Role of Off going nurse	Inform about patient status as remembered	Live assessment of patient status Inform patient & oncoming nurse about expected plan of care
Role of oncoming nurse	Listen, take notes	Identify patient's needs and set with the patient the care plan of the day
Patient participation	No participation	Convey his concerns & inquiries

**Figure 2. Comparison between current and proposed handoff process**

### **3. The Piloting**

Four nurses participated in the piloting process (three males and one female). The years of experience of nurses ranged from two to six years. The first bedside handoff started on the night intershift of February 2016 where one of the participating nurses was night duty, and the other was day duty; a third Registered Nurse (RN) was present to record the time it

takes by each patient handoff. The piloting process was performed during three night shifts, four dayshifts, and three evening shifts, forming a total of 10 patient handoffs. The patients involved were the regular assigned patients for every RN. At the end of every shift, the coming and leaving nurses initiate the process by having a small information exchange outside the patient room that includes exchanging confidential patient data such as new issues and abnormal patient assessment findings. Afterwards, they enter the patient room, the off-coming nurse introduces the on-coming nurse to the patient; both RNs perform pain assessment for the patient and review treatments and plan of the day; conduct a patient safety check (ID band, incision, IV site, PCA settings, drains/Foley, fall risk check the environment for safety issues, call bell, walker in reach, bed alarm); and ask the patient if he/she has anything to add, to request, or to ask about. The duration of every bedside handoff differed according to patients' acuities (a patient classification system that shows the level of severity of disease and how much time is needed to be allocated from the nursing staff). It took one minute when the patient acuity level is III, two minutes with patients' having level IV acuity, and three minutes with patients having an acuity V level.

#### **4. Findings**

The purpose of the piloting was to find out to what extent the assumed restraining forces is real barriers to the implementation of the proposed intershift report. The main challenges that faced nurses during the piloting process were:

(1) The risk of violating patient confidentiality in double bed rooms when the nurses discuss patient medical history and plan of care in front of another patient;

(2) The functional nursing care model at night, because during night shifts two registered nurses provide medications and charting for twenty seven patients, assisted by two practical nurses that take vital signs and provide nursing treatments to patients. So the two

night-duty nurses will handoff all 27 patients to the five day-duty nurses at the bedside and vice-versa, which is considered by nurses as very time consuming;

(3) Sleeping patient makes impossible for nurse to do bedside report.

To overcome the first challenge, the team examined the Health insurance portability and Accountability Act (HIPAA) (AHRQ, n.d) and found out that it is permitted for nurses to discuss the patient health needs even if this conversation was heard accidentally by another patient. In this way, there is no breach in patient confidentiality but precaution measures that must be taken to safeguard patient confidentiality (AHRQ, n.d).

Overcoming the second challenge, which is functional care model, nurses are saying it is time consuming; yet, the time recordings in the pilot showed that it is not. Addressing this challenge comprise extensive training on how to efficiently perform the bedside report. Studies showed that some nurses are not ready to discuss the patient confidential issues in front of the patient and might be afraid that patients' questions will delay the process and consume more time. Nurses should be instructed on how to identify questions needing a thorough explanation could be postponed till the end of the report by saying to the patient: I will be happy to come back and explain this when we finish the report.....the perception of time consuming will change after dissemination of bedside report.

To overcome the third challenge (patient asleep during night shift), nurses need to obtain consent from patients if they would like to be awakened for the report. If patients do not wish to be awakened, nurses must do the report outside the room and later on, the incoming nurse will check all the elements (Bracelet, IV, drains etc...) as well to get approval from patient ahead of time. After analyzing all the findings, the pilot team decided that the change is doable but needs to have an extensive preparation of nurses and patients before being implemented.

## **5. Pre-implementation**

In order to prepare the nurses and patients involved in the piloting process, a companion toolkit (Appendix B) (AHRQ, n.d) was used to guide nurses in explaining what will be happening to concerned patients before they start the bedside handoff. The tool was retrieved from the Agency for Healthcare Research and Quality (AHRQ) website. It defines, what, when, why, and how the bedside report will occur (report duration, members involve, what the patient should expect, and what is the role of nurses). The team decided to record the timing of every patient handoff since it was a major concern for nurses not to get delayed in the process. The approval of the nursing administration and the quality department was secured.

## **6. The training video**

In order to practically show the difference between the existing and proposed methodology, the team prepared a video that illustrates the differences. The team created two scenarios: the first scene shows two nurses doing the intershift report in a traditional way (as what is currently happening), and the second demonstrates how the process can be done at bedside. A nurse volunteered to play the role of a patient, she was instructed to ask questions and be involved in the communication. The video was recorded by a camera man in the Simulation lab of Hariri School of Nursing where all the components of a patient room were available.

## **7. Training plan**

The training will take place at the medical/surgical conference room. Key points to be discussed include the importance of bedside handoff as a patient safety issue; the patient-centered approach concept; the steps of the proposed change; and the tool to be used. A prepared video will be used to show nurses the difference between the current and proposed handoff; the training will end with a discussion session to get nurses feedback and answer their questions.

## **8. Implementation plan**

After preparing nurses and patients, the new bedside handoff will be initiated by RNs. During the first three weeks of implementation, the nurse manager and the project team members will conduct daily rounds to identify early adopters; make one to one discussions with resistant staff; and get the feedback and suggestions of nurses.

Accordingly, the team will make the necessary changes as suitable.

### **C. Refreezing Phase**

The objective of the refreezing phase is to integrate the change into practice. This will be done through providing continuous reminders of the process; incorporate reporting process into the orientation of new nurses; monitoring proper implementation through random audits; and evaluating patients' and nurses' satisfaction with new process. A staff survey will be conducted three months prior and post implementation. The chosen tool is adapted from Maxson et al. (2012) (Appendix C) tool used in a study to measure nurses accountability, work load prioritization ,communication with other health care provider and sharing accurate information.

The team will do the data collection and analysis by comparing nurses' satisfaction with the new tool and the bedside methodology. As for evaluating patient satisfaction, a phone call interview questions will be adopted from a script by Wakefield et al. (2012) (Appendix D). The team will start gathering patient satisfactions information on quarterly basis by telephone call three months before and three months after implementation. After that, some of the questions could be added to the patient satisfaction questioner of the hospital.

## **CONCLUSION**

Enhancing communication and encouraging patient participation in care are essential strategies to improve the quality and safety of patient healthcare outcomes. Many studies showed the importance of bedside report in positively affecting patient health and quality of care. Bedside report has a positive effect on both patients and nurses. It will also provide best quality of care and time management. In addition, bedside report aides in achieving three essential national patient safety goals and these are improving patient identification, improving communication between caregivers, and involving the patient and family in the care (Evans et al., 2012). Wakefield et al. (2012) recommended gradual implementation and extensive training of nurses as important ways to decrease resistance during the change process. Evans et al. (2012) stressed the importance of continuous monitoring and leaders' support as means to sustain and integrate the change.

The purpose of this project was to introduce the bedside handoff process as a new modality that will encourage nurses to involve the patient in his/her daily plan of care, and to improve the intershift communication process. The pilot study showed that there will be some challenges, yet with proper guidance and follow up this could be achievable at the medical/surgical unit and gradually on other units of AUBMC.



## APPENDICES

## APPENDIX A

### I PASS Tool

<b>I</b>	<b>Illness Severity</b>	<ul style="list-style-type: none"> <li>• <b>Stable, “watcher,” unstable</b></li> </ul>
<b>P</b>	<b>Patient Summary</b>	<ul style="list-style-type: none"> <li>• <b>Summary statement</b></li> <li>• <b>Events leading up to admission</b></li> <li>• <b>Hospital course</b></li> <li>• <b>Ongoing assessment</b></li> <li>• <b>Plan</b></li> </ul>
<b>A</b>	<b>Action List</b>	<ul style="list-style-type: none"> <li>• <b>To do list</b></li> <li>• <b>Time line and ownership</b></li> </ul>
<b>S</b>	<b>Situation Awareness and Contingency Planning</b>	<ul style="list-style-type: none"> <li>• <b>Know what’s going on</b></li> <li>• <b>Plan for what might happen</b></li> </ul>
<b>S</b>	<b>Synthesis by Receiver</b>	<ul style="list-style-type: none"> <li>• <b>Receiver summarizes what was heard</b></li> <li>• <b>Asks questions</b></li> <li>• <b>Restates key action/to do items</b></li> </ul>

## APPENDIX B

### Patient Toolkit

#### You are invited

You are invited to take part in nurse bedside shift report. You can also invite a family member or friend to take part with you.

Nurse bedside shift report happens every day between [7 and 7:30 a.m.], [3 and 3:30 p.m.] and [11 and 11:30 p.m.].

Let us know if you have any questions. We are partners in your care.

## Nurse Bedside Shift Report

### What is it?

### How can you get involved?

Being a partner in your care helps you get the best care possible in the hospital. Taking part in nurse bedside shift report is one way you can be a partner.

This brochure explains what nurse bedside shift report is and how you can get involved.



Agency for Healthcare Research and Quality  
Advancing Excellence in Health Care • [www.ahrq.gov](http://www.ahrq.gov)

## What is nurse bedside shift report?

Nurse shift changes occur when nurses who are going off duty share information about your care with nurses coming on duty. At AUBMC, we want you to be involved in shift changes to make sure you get high-quality care.

**Nurse bedside shift report** is when the nurses going off and coming on duty meet by your bedside to talk about your care. This gives you a chance to meet the nurse taking over your care, ask questions, and share important information with your nurses. Nurse bedside shift report does not replace the conversations you have with your doctor.

You can invite a family member or friend to stay during nurse bedside shift report.

## When is nurse bedside shift report?

Nurse bedside shift report happens every day as mentioned before and it usually lasts 5 minutes per patient.

## What should I expect?

During nurse bedside shift report, the nurses going off and coming on duty will:

- **Introduce themselves to you and anyone with you.** The nurse coming on duty will write his or her name on the white board in your room.
- **Invite you to take part in the nurse bedside shift report.** You should decide who else can take part with you.
- **Talk with you about your health,** including the reason you are in the hospital and what is going on with your care. The nurses will look at your medical chart.
- **Check the medicines you are taking.** The nurses will look at your IVs, injuries, and bandages. They will also follow up on any tests that were done or lab work that was ordered.
- **Ask you what could have gone better** during the last shift and what you hope to do during the next shift. For example, you may want to get out of bed. The nurse will try to help you meet this goal.
- **Encourage you to ask questions and share your concerns.** If needed, the nurse coming on duty may come back after the bedside shift report to spend more time discussing your concerns.

## What should I do?

**Listen.** You are an important part of the health care team. We want to make sure you have complete and timely information about your care.

**Speak up.** If you have questions or concerns, nurse bedside shift report is the perfect time to raise them.

**Ask questions if something is confusing.** If the nurses use any words or share any information you don't understand, feel free to ask them to explain it.

## APPENDIX C

### Nurses Questioner Sample

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female				
Years of registered nursing experience: _____				
<b>1. Nurse-to-nurse shift report makes people accountable.</b>				
1 Strongly agree	2 Agree	3 Neither agree nor disagree	4 Disagree	5 Strongly disagree
<b>2. Nurse-to-nurse shift report provides adequate communication between nursing staff at the change of shift.</b>				
1 Strongly agree	2 Agree	3 Neither agree nor disagree	4 Disagree	5 Strongly disagree
<b>3. Nurse-to-nurse shift report helps me prioritize my workload.</b>				
1 Strongly agree	2 Agree	3 Neither agree nor disagree	4 Disagree	5 Strongly disagree
<b>4. Nurse-to-nurse shift report allows me to perform shift change medication reconciliation.</b>				
1 Strongly agree	2 Agree	3 Neither agree nor disagree	4 Disagree	5 Strongly disagree
<b>5. Immediately after nurse-to-nurse shift report, I am able to communicate with physicians regarding patient care.</b>				
1 Strongly agree	2 Agree	3 Neither agree nor disagree	4 Disagree	5 Strongly disagree

## APPENDIX D

### Nurses Questioner Survey

#### **Patient Interview Questions**

- Did your nurse ask you to think of questions before the shift report occurred? Yes/No
- Did your last nurse introduce you to your current nurse? Yes/No
- Did the nurses allow you to ask questions during the shift report? Yes/No
- Were your questions answered to your satisfaction? Yes/No
- Did either of your nurses discuss your goal for today with you? Yes/No
- To what extent did you feel involved in the shift report communications?  
Very Much, Quite a Bit, Somewhat, Very Little, Not at All.
- How satisfied were you with this most recent shift report? Very Satisfied, Satisfied, Dissatisfied

Adapted from (Wakefield et al. 2012)

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