

# BEDSIDE SHIFT REPORT IMPROVES PATIENT SAFETY AND NURSE ACCOUNTABILITY

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**W**hy bedside shift report? The short answer: Patient safety.

The truth is, thousands of patients are cared for every day in US emergency departments, resulting in thousands of shift changes and thousands of opportunities for error. According to the Institute of Medicine's report *To Err is Human: Building a Safer Health System*, between 44,000 and 98,000 people die in US hospitals each year because of preventable health care errors.<sup>1</sup>

Even greater are the numbers of preventable errors that do not result in death but lead to acute or chronic illness, injury, and/or disability. Financial costs from errors are also substantial and include lost income, reduced productivity, increased health care costs, and inflated health insurance premiums.<sup>1</sup>

The emergency department is also a high-risk environment in which additional safety factors must be considered. The National Quality Forum identified these as multiple individuals involved in the care of a single patient; patients with high-acuity illness or injury; rapid health care decisions under severe time constraints; high volume of patients and unpredictable patient flow; barriers to communication with patients, families, and other health care professionals; and interactions with multiple types of diagnostic and/or treatment technology.<sup>2</sup>

## Other Benefits

Bedside shift report is also an excellent way to build employee teamwork, ownership, and accountability. In addition, it responds directly to a number of the Joint

Commission's National Patient Safety Goals, including goal 1 ("improve the accuracy of patient identification") because we check the patient's armband and ask the patient his or her name and birth date as identifiers, goal 2E ("improve the effectiveness of communication among caregivers: managing hand-off communications," with particular attention to ensuring the opportunity for asking and responding to questions), and goal 13 ("encourage patients' active involvement in their own care as a patient safety strategy.")<sup>3</sup>

## What Is in It for Staff

Although it sounds simple, staff may be resistant to this process for any number of reasons. However, here is the really wonderful thing: Bedside shift report drives staff ownership and accountability. If you have ever heard staff comment, "You should see the way the night shift left their rooms!" or "The intravenous line is dry, his sheets are wet, and there are two full urinals on the Mayo stand!," you will appreciate the way bedside shift report creates ownership and accountability. Here is what is in it for staff:

- Opportunity for real-time conversations. If I go into the room and see that the last nurse has left it in disarray, I can say, "Kim, why don't you empty the urinals while I check the patient and update the whiteboard?" If I, as a staff nurse, understand that bedside report is an expectation and understand that someone is going to be checking both my patients and my rooms, as well as verifying my charts, then I am going to be more likely to ensure everything is in order before that shift change.
- More time. Although you might hear initial staff concerns that it will "take too long" or that they "don't have time," the reality is that nurses will be with the patient for 3 to 5 minutes while they physically check the patient, update the whiteboard, and do an environmental check (e.g., Is the intravenous line patent? Are the side rails up? Does the patient have the call light within reach?). Because it is a quick physical check on the patient, the nurse can ensure the patient's room is in good condition and the patient is safe and then check on other patients.

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ED Bedside Shift Report Using SBAR(T) Format	
S = situation B = background A = assessment R = recommendation T = thank you	
<b>S</b>	<p><b>Offgoing Nurse-</b></p> <ul style="list-style-type: none"> <li>✔ Manage Up—"I'm going home now. Samantha will be your nurse for the next shift. I've worked with Samantha for five years and I can tell you I'm leaving you in good hands. I always hear such nice things about her from her patients."</li> </ul> <p><b>Oncoming Nurse-</b></p> <ul style="list-style-type: none"> <li>✔ Introduce self using AIDET (Acknowledge, Introduce, Duration, Explanation, Thank You)</li> <li>✔ Update white board</li> <li>✔ Check armband while asking patient to state his/her name and date of birth</li> </ul>
<b>B</b>	<p><b>Offgoing Nurse-</b></p> <ul style="list-style-type: none"> <li>✔ Involve patient in change of shift report—"I'm about to give report to Samantha. Please listen so at the end you can ask any questions or fill in any additional information that Samantha will need to know to care for you during her shift."</li> <li>✔ Give a brief update on patient's chief complaint and what treatments/medications have been provided</li> <li>✔ Update on any pending tests or treatments (i.e. lab/radiology)</li> <li>✔ Discuss any special needs (i.e. altered mental status, fall risk, isolation precautions)</li> </ul> <p><b>Oncoming Nurse-</b></p> <ul style="list-style-type: none"> <li>✔ Ask patient if they have any questions</li> </ul>
<b>A</b>	<p><b>Offgoing Nurse-</b></p> <ul style="list-style-type: none"> <li>✔ Give explanation—"We are going to do a quick physical assessment together since we are changing shifts."</li> <li>✔ Inform the oncoming nurse of what you have assessed and or noted during your shift</li> <li>✔ Include any information or tasks that you have completed</li> <li>✔ Mention what the oncoming nurse will need to complete or follow-up on</li> </ul> <p><b>Oncoming Nurse-</b></p> <ul style="list-style-type: none"> <li>✔ Review chart/check documentation</li> <li>✔ Conduct a quick physical assessment and check all IV sites/pumps for accuracy</li> <li>✔ Assess patient's pain using a pain scale</li> </ul>
<b>R</b>	<p><b>Offgoing Nurse-</b></p> <ul style="list-style-type: none"> <li>✔ Review all orders and plan of care with oncoming nurse (tests, treatments, medication therapy, IV sites/meds)</li> <li>✔ Include relevant medications that have been ordered and any ancillary or support services that are working with the patient such as respiratory therapy, radiology, social services, etc.)</li> <li>✔ Ask the patient- "Do you have any questions? Is there anything else the nurse needs to know at this time?"</li> </ul> <p><b>Oncoming Nurse-</b></p> <ul style="list-style-type: none"> <li>✔ Validate orders/plan of care</li> <li>✔ Ask any questions of offgoing nurse</li> </ul>
<b>T</b>	<p><b>Thank the Patient-</b></p> <p><b>Offgoing and Oncoming Nurse-</b> Prior to leaving the room, ask the patient the following:</p> <ul style="list-style-type: none"> <li>✔ Is your <b>pain</b> under control?</li> <li>✔ Do you understand the <b>plan of care</b>?</li> <li>✔ Do you know what you are waiting for and what will happen next?</li> <li>✔ Do you have any <b>concerns</b> we can address?</li> </ul> <p><b>Use Closing Key Words-</b></p> <ul style="list-style-type: none"> <li>✔ <b>Offgoing Nurse-</b> "Samantha will take very good care of you. Thank you for allowing me to care for you today."</li> <li>✔ <b>Oncoming Nurse-</b> "Is there anything you need right now? I'll be back to check on you in about an hour."</li> </ul>

FIGURE 1

ED bedside shift report using SBAR(T) format. IV, intravenous; meds, medications.

- A way to transfer trust. Bedside shift report is a warm handoff, allowing the patient to say goodbye and thank the nurse who has cared for him or her during his or her stay.
- Mentoring for new nurses. It is good discipline for another nurse to review a new nurse's documentation, physically see their patients, and review their assessments, medication therapy, and environmental factors

### Sample Bedside Report Dashboard

	n size	Nurse took time to listen	Nurses informative re: treatments	Informed about delays	Staff cared about you as a person	How well pain was controlled
Baseline		50%	58%	28%	45%	58%
Goal- In Percentile Rank		50%	50%	50%	50%	50%
Week of:						
7/29 - 8/4	13	51%	76%	93%	90%	97%
8/5 - 8/11	11	87%	57%	58%	66%	8%
8/12 - 8/18	11	71%	81%	19%	21%	50%
8/19 - 8/25	11	87%	87%	6%	72%	67%
8/28 - 9/1	8	14%	81%	25%	26%	75%
9/2 - 9/8	11	93%	93%	78%	88%	91%
9/9 - 9/15	1	72%	61%	69%	81%	64%
9/16 - 9/22	1	62%	99%	99%	99%	81%
9/23 - 9/29	3	90%	99%	99%	99%	99%
9/30 - 10/6	7	76%	80%	92%	82%	76%
10/7 - 10/13	1	99%	99%	91%	99%	99%

Baseline= May - July

Report = Pt response by Date of Discharge. Note: Weekly results may change over time

FIGURE 2

Sample bedside report dashboard. *Pt*, patient.

every 12 hours. Who knows? A new nurse could be so busy focusing on her clinical skills that she forgets to think about patient comfort measures.

#### What Is in It for Patients

Bedside shift report increases patients' involvement in their plan of care in many ways. They see and hear from the team of professionals who are providing their care. As a result, they feel more comfortable asking questions or voicing concerns; they are reassured that everyone is receiving the necessary report about what is going on with them; they feel more informed about their care, which makes them less anxious and more compliant with the plan of care; they are more satisfied because they know that things are being monitored throughout the shift; they know who their nurse is on every shift; and bedside shift report reduces the perception that "no one is around" during shift change when sentinel events are more likely to occur.

#### Before You Begin

However, before attempting to implement this process, be sure you have already hardwired leader rounding on staff and leader rounding on patients to ensure that your staff are engaged and that you have a process in place to obtain feedback from patients. (See previous articles on rounding for outcomes and discharge phone calls.<sup>4,5</sup>) You will also want to discuss with staff why you are implementing bedside shift report. Review the process

and gain agreement. Finally, verify outcomes through leader rounding on patients.

The key to successfully hardwiring bedside report is to implement processes that clearly define the responsibility from one caregiver to another, standardize the communication process, and allow for an interactive exchange between the parties involved. Bedside shift report decreases the potential for near misses through a transfer of responsibility and trust and by using standardized communication.

#### How to Implement Bedside Shift Report

Bedside shift report is meant to be fast. Before entering the patient's room, the incoming nurse will look at the chart and go over the medical history, treatments, and anything pending while at the desk . . . just like he or she normally does. Then, the outgoing and incoming nurses will go to the bedside together, where the outgoing nurse "manages up"—positions in a positive light—the incoming nurse and introduces him or her.

The incoming nurse's role is to ask the patient his or her name and date of birth and to check the armband for safety and introduce himself or herself. He or she should update the whiteboard in the room and double-check pumps as well as all intravenous medications for accuracy and the patient's safety.

Before bedside shift report, advise and educate the patient that it will be occurring. (I know some emergency departments that even provide patients with a letter to explain and manage up the process.)

Then, use the SBAR (situation-background-assessment-recommendation) communication technique. It provides a framework for communication between members of your health care team. SBAR is an easy-to-remember and concrete mechanism useful for framing any conversation, including those held in front of the patient. This technique facilitates an easy, focused way to set expectations and relay important information (Figure 1).

#### Tips for Success

- Be sensitive to privacy and information shared in front of the patient. Use key words to let the patient know you will maintain his or her privacy and keep his or her information safe. Discuss sensitive information away from the patient's bedside to maintain confidentiality.
- Educate the incoming nursing team about bedside shift report if they are float or registry personnel.
- Exclude opinions. Report is a time for facts. If a nurse is unhappy with the patient (or physician caring for the patient), the bedside report is not the time to vent. Criticism makes the nurse appear less credible.
- Avoid putting a nurse on the spot in front of the patient and/or family.

If the incoming nurse has a question or needs clarification about a sensitive issue, wait until after bedside shift report is complete.

#### Track and Follow-up

Just as we recommend when implementing other processes (e.g., rounding for outcomes, discharge phone calls), you will want to formalize training of staff on bedside shift report and ask an evaluator to complete a competency assessment to ensure standardization and compliance. Then, report back wins and opportunities regularly to staff at huddles and stand-up meetings using results from the bedside report dashboard (Figure 2).

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