5-2022

Bedside Shift Report and Patient Satisfaction

Kasandra R. Johnson
krj18c@acu.edu

This doctoral project, directed and approved by the candidate's committee, has been accepted by the College of Graduate and Professional Studies of Abilene Christian University in partial fulfillment of the requirements for the degree

Doctor of Nursing Practice

Nannette W. Glenn, Ph.D.

Dr. Nannette Glenn, Dean of the College of Graduate and Professional Studies

Date: 2/3/2022

Doctoral Project Committee:

Dr. Faisal Aboul-Enein, Chair

Lynx McClellan

Dr. Lynn McClellan

Donna R. Atobajeun

Dr. Donna Atobajeun

Abilene Christian University

School of Nursing

Bedside Shift Report and Patient Satisfaction

A doctoral project submitted in partial satisfaction

of the requirements for the degree of

Doctor of Nursing Practice

by

Kasandra R. Johnson

May 2022

Dedication

I would like to dedicate this project to my family and all those who have encouraged me along the way. Thank you all for your warm, wonderful words of encouragement. Especially my mom, who has always been a true inspiration through her words as well as her actions.

Acknowledgments

I would like to thank my Lord and Savior, Jesus Christ. Through him, I have accomplished my goal. I would also like to thank my project chair. Dr. Faisal, along with my committee members Dr. Lynn McClellan and Dr. Donna R. Atobajeun. Thank you all for your input and feedback. This is what made this project a success.

Abstract

Each year, millions of deaths worldwide are caused by medication errors in hospitals. Some of these errors are accounted for through miscommunication during the change of the nurse shift report. One of the Joint Commission's 2019 national patient safety goals for hospital programs was to improve communication effectiveness among caregivers since mistakes in a caregiver's communication accounted for 37% of severe patient injuries. Safety is threatened by patients not being included. Therefore, adopting the bedside shift report allows patients to be actively engaged, reinforcing nurse-patient communication. The bedside shift report enables nurses to provide safe, high-quality, patient-centered care at the bedside. At the time of this project, a 24-cardiac bed unit at a community hospital in Louisiana lacked a bedside shift report. Surveillance of the nurse shift report at the nurses' station unveiled countless communication gaps. The Hospital Consumer Assessment of Healthcare Providers and Systems survey measures patient perception of their hospital experience. The scores from April 2019 revealed a need for improvement in nurse-patient communication at the unit level. The data were compared for the communication with nurse dimension of the Hospital Consumer Assessment of Healthcare Providers and Systems scores preimplementation of the bedside shift report from April 2020 (July 2018–June 2019 discharges), with survey scores postimplementation of the bedside shift report from April 2021 (July 2019–June 2020 discharges), using the longitudinal data analysis. The four specific questions in the Hospital Consumer Assessment of Healthcare Providers and Systems survey related to communication with the nurse and comparing data preimplementation and postimplementation of the bedside shift report were examined. This quality improvement research project aimed to assess the bedside shift report on patient satisfaction in care delivery

for the communication with nurse dimension in the Hospital Consumer Assessment of Healthcare Providers and Systems survey.

Keywords: HCAHPS survey, bedside shift report, nurse-patient communication, patient satisfaction, communication with nurse dimension, nurse shift report

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

Effective communication is essential for providing high-quality, patient-centered care that is safe. Safety is accomplished by good patient outcomes in care related to nurse communication (Reinbeck & Fitzsimons, 2013). Good nurse-patient communication is not only a safety characteristic in healthcare organizations, but it is also important from a financial perspective. Healthcare organizations should cultivate and investigate effective communication processes to deliver excellent healthcare experiences for their patients, especially when Medicare reimbursement is expected (Reinbeck & Fitzsimons, 2013). Patient satisfaction surveys have become increasingly important as their scores help to determine Centers for Medicare and Medicaid Services (CMS) reimbursement (Sobel et al., 2019).

The measurement of patient satisfaction has become an integral component of health care over the past two decade (Stephens et. al., 2020). Patient satisfaction is the key indicator and evidence for standard service, and it is relevant to be studied as it presents protuberant facts on the performance of health providers' and the quality of hospitals' management (Wardah & Wardani, 2020). The bedside shift reports (BSRs) are important transactions between offgoing and incoming nurses that occur at the bedside. Patient-centered care is paramount to patient satisfaction in communication with the nurse. According to Elue et al. (2020), carrying out the BSR maximizes patients' experiences while in the hospital. Patient-centered care is demonstrated through this process performed at the patient's bedside.

The COVID-19 pandemic has coined a new term: *the new normal*, meaning "a formerly atypical or unfamiliar situation that has become expected, usual, or standard" (Reimer, 2021, p. 1). Nurse managers (NMs) must implement the best available evidence-based practices (EBP) to guide a new normal, an environment like the current, unlike the familiar one. The BSR is

currently preferred as it addresses most of the barriers that limit effective communication between the patient and the nurse (Wakefield et al., 2012).

Evidence shows poor patient outcomes and increased dissatisfaction when healthcare quality cannot align with patient and family values (Goldfarb et al., 2017). The BSR improves patient experience and increases satisfaction in care related to communication with the nurse. A formal introduction occurs from the offgoing nurse to the incoming nurse, the BSR creates an atmosphere that enhances face-to-face communication, which is key to the nurse-patient relationship. Patients are invited to comment or ask questions during the BSR. Valuable information is exchanged, and patients' needs are clarified. Patients experience patient-centered care because, at the time of the BSR, their condition, environment, and equipment are checked. Empirically, research has established evidence of an association between patient experience scores and patient satisfaction with care delivery (Kumah, 2019).

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) captures patient's experience in communication with doctors and nurses, the responsiveness of hospital staff, communication about medicines, cleanliness and quietness of the hospital, discharge information, transition to posthospital care, and overall rating of the hospital (Centers for Medicare and Medicaid Services, 2020). The HCAHPS presents a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care (Centers for Medicare and Medicaid Services, 2020). Healthcare organizations are continually transforming in response to technological advances, increased consumer expectations, governmental regulations, and care associated with bedside nursing. Mentioned in the Institute of Medicine (IOM) executive summary entitled "A Bridge to Quality" is patient-centered care

(Kohn et al., 2000). The BSR aligns with IOM's statement that communication safeguards patient-centered care when evidence-based practices are applied (Kohn et al., 2000).

Background

The HCAHPS scores for the *communication with nurse dimension* from April 2019 revealed the need for improvement in patient satisfaction. Consequently, the NM of the cardiac unit completed a gap analysis to establish EBPs for the BSR compared to the current approach. Evidence-based practice data on the BSR is the substance applied to fill the knowledge gap. A practice change demands strong NMs and staff champions for change in the delivery of care practices (Summers et al., 2012). The Joint Commission (2002) initially launched improved *effectiveness of communication caregivers* as a National Patient Safety Goal in 2002. This goal requires institutions to create a standardized communication approach to the nurses' shift report (NSR), including a chance for nurses and their patients to have a question and answers session.

The nurses on the cardiac unit use the traditional method as the primary reporting method. The traditional method is the NSR outside the patient's room. Other clinical units have adopted the BSR as a standardized nurse-patient communication approach. This lack of direct contact causes nurses not to confirm the patient's actual condition at the time of the NSR, compromising efficient patient care and conversation (Khuan & Juni, 2017). One of the most fundamental components of quality nurse-patient care is effective communication that ensures patient safety. The literature on patient care and their experience suggests that patient satisfaction is closely related to individuals' characteristics, interaction with the nurse, and perceptions of the time they must wait for care (Foster et al., 2019). Effective nurse-patient communication occurs when safety and quality remain intact and when patients and their families experience empowerment to engage in their family member's care.

Experience has shown from the severe acute respiratory syndrome (SARS) crisis that patients are at risk of boredom, loneliness, fear, anxiety, anger, insomnia, and a taboo feeling (Galehdar et al., 2020). Nurses are essential workers in the fight against COVID-19. These essential workers are the registered nurses (RNs). These RNs are valuable resources who recognize their patients' needs, especially during this COVID-19 crisis (Galehdar et al., 2020). Furthermore, the BSR is more efficient than the shift report recorded or given at the nurses' station since it takes less time (Halm, 2013). With the decreased time it takes to get the information, the incoming shift nurse can begin care sooner (Evans et al., 2012). After applying the BSR, the nurse's average reporting time decreased by approximately 16 minutes from 45 minutes. Nurse and patient satisfaction increased to 41% from 37% (Rifai et al., 2020). Therefore, there was no need to hold a group meeting like before, where the offgoing nurse briefs the incoming nurse. After implementing the BSR, more nurses commented that they could prioritize their work more and provide better patient care (Baker, 2010).

Other outcomes of the BSR include increased patient satisfaction with care delivery. When investigating the effects of the BSR, scholars focused on three groupings: nurse satisfaction, patient satisfaction, and good patient outcomes. When properly implemented, the BSR improves patient satisfaction by engaging them in developing a nurse-patient relationship. According to Caruso (2007), the BSR facilitates the creation of an environment that promotes patient participation. Patients will gain knowledge of their treatment plan; they will likely spend less time in the hospital before being discharged. Recent researchers reported that the BSR is currently preferred as it addresses most of the barriers that limit effective communication between the patient and nurse (Wakefield et al., 2012). More healthcare organizations are adopting the BSR since the approach increases the patient's involvement in the treatment

process. However, implementing the BSR, which puts evidence-based research into practice, is incredibly challenging.

Problem Statement

In the United States, the primary cause of injury and death is unnecessary errors due to miscommunication. The impact of miscommunication leads to roughly speaking 1,000 deaths per day and scores in $2.9 billion spent each year nationally (Kohn et al., 2000). According to the Agency for Healthcare Research and Quality (2013), an estimated 80% of serious medical errors involve miscommunication between caregivers when patients are transferred or handed off. One of the Joint Commission's 2019 National Patient Safety Goals for hospital programs is to improve communication effectiveness among caregivers (Joint Commission, 2002).

Communication is essential to the care delivery process since it ensures the patient receives safe, quality care, which improves patient outcomes. The NSR is a widely used process of nurse-to-nurse communication. Nurses transfer essential information to ensure the delivery of care is safe. There is a need to improve how nurses communicate with their patients during the delivery of care. Approximately three million nurses are working in various settings; nurses are not only vital in number, their authority and clinical expertise in their healthcare backgrounds are strongly related to patient safety and quality of care (Stimpfel et al., 2020). The HCAHPS is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience.

The NM of the cardiac unit met with the nursing staff to brief them on the unit's low HCAHPS scores and collaborate to solve patient satisfaction with nursing care communication. The communication with nurse dimension of the HCAHPS scores from April 2019 revealed a patient satisfaction score of 72%. These scores are lower than the state, which is 85%, and less

than the national of 91% for patients who report satisfaction with communication with nurses. The BSR will tackle poor communication between nurses and their patients, as evidenced by the scores shared by the NM of the cardiac unit within the healthcare organization.

Healthcare organizations use patient satisfaction surveys to assess the communication with nurse dimension associated with patient-family satisfaction with information shared in a timely manner about changes in the patient's condition (Kullberg et al., 2017). Various research studies suggested that the NSR at the bedside increased patient experiences. The cardiac unit does not use the BSR; however, other divisions include the BSR as a nurse-patient communication process within healthcare organizations.

Purpose Statement

Hospital surveys revealed that HACHPS scores in nurse-patient communication could be improved. As a result, this Doctor of Nursing Practice (DNP) scholarly project's purpose was to understand better the delivery of nursing care through communication and patient satisfaction. The HCAHPS scores established patient satisfaction with nurse communication in implementing the BSR. Nurse managers must implement processes that increase the nurses' skills to communicate and coordinate the patient's plan of care (Prosser et al., 2020). Healthcare organizations and nursing leaders are focused on changing their settings to ensure patient safety and satisfaction. Evidence showed poor patient outcomes and increased dissatisfaction when healthcare providers cannot align with patient-family goals and values of care processes (Goldfarb et al., 2017). The HCAHPS is a reliable method for measuring patient satisfaction with nursing communication. This study showed the relevancy of survey scores reported by patients who experienced the implementation of the BSR. There were notable data the BSRs compared to the NSR completed outside the patient's room increased patient satisfaction.

The BSR strengthens the bond between patients and nurses, benefiting both parties in numerous ways. First, simplicity is convenient for transparency. Patients acquire more information on the topic of their health and personal issues through interaction with nurses and learning ways of improving self-care. The procedure invites patients and their families to engage by listening and participating, thereby improving accuracy, quality, and safety. The BSR ensures the satisfaction of both nurses and patients. The NMs must adopt a more modernized NSR that promotes efficiency by discouraging irrelevant or wrong information. According to Rush (2012), various NSRs across different hospital settings during care are risky; therefore, it should be a point of concern for nurses.

This quality improvement project enabled the NM of the cardiac unit to gain knowledge and positively influence care delivery and communication among nurses and patients. Subsequently, in a technologically advanced era, patients watch the news and frequently browse the internet, and they are more likely to access the internet whenever they want to diagnose their illnesses. Patients are aware of numerous irreversible errors that can harm them and cost them their lives during hospitalization. As a result, they expose themselves to misdiagnosis. The BSR characterizes a chance for patients to discover potential data inconsistencies, as well as mistakes and misunderstandings (Bressan et al., 2019).

Significance of the Study

The NM of the cardiac unit completed a gap analysis to establish evidence-based best practices for the NSR compared to the current approach. The current NSR approach is completed outside the patient's room; there were several interruptions during the process, consisting of call lights and disruptions by patients or family members. The BSR is an essential part of their daily nursing care. Patient data obtained in the NSR was frequently unreliable. Consequently, great are

the number of avoidable mistakes that do not cause death but lead to acute or chronic illness, injury, and disability. The average cost for a fall injury is $35,000; the BSR reduces these occurrences and adverse events, for example, pressure ulcers and falls (Evans et al., 2012).

Errors in care are overwhelming for the patient and costly for the healthcare organization. The miscommunication impact leads to approximately 1,000 deaths per day, resulting in $2.9 billion spent each year nationally (Kohn et al., 2000). Miscommunication accounts for 30% of all malpractice claims, with healthcare organizational payout of $2.9 billion spent annually throughout the nation. Failure to communicate was a common malpractice claim against nurses identified in the medical and nursing literature between 2000 and 2012 (Watson, 2014). According to the National Practitioner Data Bank report (2012), between 1990 and 2011, all types of professional nurses had a total of 9,278 monetary malpractice payments, with an approximate mean of $282,297 per claim.

The NSR is appropriate and practical at the patient's bedside. During the procedure, the patient is free to ask any questions that may concern them about their health and treatment. Implementation of the BSRs by nurses positively impacts patients' ability and willingness to adhere to treatment plans since they understand the process better. Family members can also listen to patient information that nurses communicate during the BSR (Riesenberg et al., 2009). Currently, the offgoing nurse reports to the incoming nurse outside the patient's room. This approach eliminates the patient from the NSR and limits the nurse's ability to offer patient-centered care.

The BSR increases nurses' accountability. During this process, the nurse authenticates the patient's health history, diagnoses, physical assessment, and care plan in preparation for discharge to a transitional care facility or home. Nurses can create a working relationship with

their patients by implementing the BSR. This approach creates a peaceful atmosphere that focuses on patients' safety by allowing nurses to check on their physical security without delay. The offgoing nurse can end the shift on time and leaving on time stops accidental increments over time and allows the incoming nurses to start patient care sooner (Evans et al., 2012). The nursing staff is convivial with the project implementation. A strengths, weaknesses, opportunities, and threats (SWOT) analysis determined the opportunities and barriers for correction (see Appendix A). The strengths were the nurses' receptiveness to change and contemporary practices.

Nature of the Project

The objective was to enhance the patient experience in hospital care by applying the BSR to the cardiac unit. Currently, the clinical unit has the traditional NSR policy in place. Survey scores revealed that patient satisfaction increased. The quality improvement research project measured patients' perceptions of their experiences in the hospital's care delivery system for the communication with nurse dimension of the HCAHPS. The NM of the cardiac unit updated the results of the survey to the nursing staff. She updated the nursing staff during the unit meetings, and the HCAHPS scores were on dashboards in various areas of the unit.

The HCAHPS scores for the communication with nurse dimension after implementing BSRs were measured. The objective, to increase patient satisfaction scores and achieve the project's set results, was completed by applying the BSR. Evaluating quality patient care involves measurements of patient experience and standards of patient satisfaction with care delivery. A patient's perception of their hospital experience is measured in satisfaction related to nurse communication**.** The HCAHPS captures patient experiences. This study used the population, intervention, comparison, and outcomes (PICO) criteria to compare the HCAHPS

scores of the communication with nurse dimension using the BSR approach compared to the NSR outside the patient's room. The survey scores focused on the communication with nurse dimension of the instrument, the HCAHPS. The data collection and analysis of survey scores showed the scores of the four specific questions for the communication with nurse dimension.

PICO Question

For adult patients on a cardiac unit, does the BSR compared to the NSR completed outside the patients' rooms increase the HCAHPS survey scores for the communication with nurse dimension?

- Population: Adult patients in the cardiac unit.
- Intervention: The BSR.
- Comparison: The NSR was completed outside the patient's room.
- Outcome: Increase the HCAHPS scores for the communication with nurse dimension.

The study's population was adult patients in the cardiac unit. The participants were ≥ 18 years old and were admitted to this clinical specialty unit. The unit handles medical or surgical and telemetry patients. Some of the necessary diagnoses for patients receiving care in this unit include cardiac dysthymias, coronary artery disease, and myocardial infarction.

The BSR is completed at the end of an eight- or 12-hour shift between the offgoing nurse and the incoming nurse, an action that occurs at the bedside and includes the patients. The BSR allows more room for transparency and accountability. This method enhances nurse-patient communication. The NSR performed outside the patient's room is the traditional process of nurse-to-nurse communication. Usually, at the nurses' station, away from the patient, the NSR is carried out. Some might opine that the said system is more stress-free for the nurse because it does not include patients and is primarily an internal affair for the hospital.

The HCAHPS survey (also known as the CAHPS® Hospital Survey or Hospital CAHPS) is a set of core questions, with one dimension comprised of patient perspectives on nurse-patient communication (see Appendix B; Centers for Medicare and Medicare Services, 2020). The HCAHPS presents a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care (Centers for Medicare and Medicaid Services, 2020).

Hypothesis

A clear relationship exists between increased patient satisfaction in nurse-patient communication and an increase in the HCAHPS scores of the communication with nurse dimension. The BSR improved patient satisfaction by keeping patients better informed about their care and improved nurse-patient communication. Therefore, the methodology in the project context was quantitative.

Theoretical Framework

The NM of the cardiac has the drive to guide and maintain improvement changes at the bedside. Lewin's three-step model of change management was emphasized through the nursing literature as a framework to change care at the bedside (Shirey, 2013). Lewin's three-step change management framework (see Appendix C) transfers the procedures used to provide care at the patient's bedside (Wojciechowski et al., 2016). The intricacy of healthcare demands interprofessional collaboration to guide and maintain paramount outcomes for high-quality patient care. Nurse managers' and executives' formal training supports the frequent use of Lewin's three-step model of change management.

The complexity of healthcare demands the ongoing and continuous collaboration of ideas to make and sustain constructive improvements. Healthcare organizations must maintain

equilibrium when changing adaptive systems, such as implementing a shift change report. Change is a necessary step for these organizations to survive in the multifaceted healthcare environment. The model proposes that positive forces influence successful implementation and counter the driving forces that support the status quo.

There were positive outcomes of the BSR if the cardiac unit followed the three-step stage proposed by Lewin in his change theory model. The first step would be to unfreeze by persuading people of the benefits and ensuring that they are mentally prepared to accept change. The unfreezing stage usually involves getting the staff and patients to recognize the need for change. Before planning for implementation, research facilitators create awareness by holding meetings to communicate the various stakeholders' proposals.

This study identified the possible root cause of the low HCAHPS scores for the communication with nurse dimension to be the current shift report process used to communicate patients' information between nurses. The research team distributed the bedside report brochure (see Appendix D) to the RNs to promote comprehension. In addition, a meeting was held to discuss the BSR implementation with the patients, RNs, and other relevant stockholders. The brochures are on the patients' whiteboards. This action enables patients to be readily involved in investigating the BSRs effectiveness in the communication in the nurse dimension of the HCAHPS.

The next step is the change phase. Consequently, moving to this level requires change in behavior, attitudes, and values (Tran & Gandolfi, 2020). The organization will be required to create a concise picture of the desired scores and the accruing benefits for the stakeholders to agree on its implementation. For nurses to be skilled in delivering services using the BSR, they will receive training and continuous assessment of their efficiency.

The research team corrects the RNs until the patient's bedside reporting becomes less confusing and more natural. Despite the need to be supervised, the research facilitators should avoid making suggestions during the transition since nurses are more in touch with the patients. This way, the nurses feel empowered and develop a sense of ownership toward the approach. This movement stage gets nurses and patients to accept the new form of the reporting experience with an open mind. The research facilitators can also use role-playing exercises to improve the nurses' communication skills and mitigate their anxiety.

The final step is known as refreezing. This step ensures constant monitoring of the changes. The phase is a mark of stability for the research facilitators and the organization. Since its implementation, the stakeholders agreed to adopt the changes; the incorporated changes can be stressed and internalized by nurses and patients alike. For transformations to be significant, they must be enforced by those promoting change and the resisting forces that maintain the status quo. The driving forces should set up clear communication channels to ensure that nurses have regular debriefing sessions for performance evaluations. Change managers have used Lewin's change model to decrease resistance to change since the method guides strategic planning. Through Lewin's model of the refreezing step, the institution's management should ensure that the implementation is flexible, not immune to new changes in the future.

Definitions

Bedside report. The change-of-shift reports between the incoming nurse and the offgoing nurse that takes place at the bedside.

HCAHPS survey. The HCAHPS is a standardized survey instrument and datum collection method that measures patients' hospital care perspectives.

Patient perception. Patients' views of services rendered and treatment outcomes, which are observed to assess the quality and delivery of healthcare.

Patient satisfaction. A measure of quality in care, patient satisfaction provides healthcare professionals insights into several treatment characteristics, involving the effectiveness of their care and their level of receptiveness.

Shift reports. Shift reports occur when there is a transfer of accountability and responsibility from one nurse to another.

Scope and Limitations

Inclusion criteria in this inquiry are randomly selected patients who completed the survey between 48 hours and six weeks after discharge from the cardiac unit. Regardless of the form of health insurance coverage, they were 18 years of age at admission, alive at discharge, and stayed overnight in the hospital. Patients discharged from preimplementation of the BSR and patients discharged from July 2019 to June 2020 postimplementation of the BSR. Families were excluded from the project due to changes in the visiting policy in response to COVID-19. The extraction of data for analysis was limited to the cardiac unit.

Chapter 2: Literature Review

This chapter provides an overview of the literature that guided this DNP scholarly project. This literature review provides context that guided this problem of interest (POI). The HCAHPS survey scores were analyzed to uncover satisfaction rates with implementing the BSR. This DNP scholarly project aimed to understand better the delivery of nursing care through communication and patient satisfaction.

Historical Overview

Lewin's three-step change management model was emphasized through nursing literature as a framework to change care at the bedside (Shirey, 2013). Lewin's three-step change management framework (see Appendix C) transforms procedures used to provide care at the patient's bedside (Wojciechowski et al., 2016). Nurse managers have discovered this fast approach to guide and maintain quality improvement changes at the bedside.

Current and Historical Research Findings

Extensive documentation demonstrated that the BSR, which included the patient-family, promoted and increased timely and effective communication between nurses, patients, and families (Clark et al., 2016; Malfait et al., 2019). The handling of patient data during the NSR was essential because precise shift reports enhanced safety and the continuity of care (Tan, 2015). In Williams' (2018) article, nurses used the traditional shift; however, the BSR allowed transparency and accountability (Small & Fitzpatrick, 2017). This process also allowed nurses to exchange the patient's information at the bedside while enabling the ill person to add insight and ask questions. Scholars have widely studied the impact of the BSR on healthcare, yet little information exists on the effects in the cardiac unit. According to Small and Fitzpatrick (2017), nurses preferred traditional shift hand-off for comparably less stress, and "nurses indicated

significantly increased nurse accountability, patient involvement, and increased safety with the BSR" (Small & Fitzpatrick, 2017, p. 45).

Tan (2015) conducted a study to determine the effects of the BSR on nursing professionals. The author established that this practice allowed nurses to develop a personal relationship with the patient, enabling the latter to feel secure and comfortable asking questions. As a result, the communication between the two parties improved, leading to high HCAHPS scores, which indicated patient satisfaction with nurse-patient communication. Compared with the traditional shift reports, Tan (2015) showed that the old approach excluded patients during reporting, denying nurses an opportunity to establish a rapport and a relationship with the client. Although this study did not focus on the cardiac unit, the findings did not differ among the patients suffering from heart diseases.

According to (Williams, 2018), the BSR allowed the patient to participate in the NSR process by asking questions that provide insight into the treatment process. The author also added that the procedure offered the incoming nurse an opportunity to see and spend the first half-hour of their shift observing the patient, contrary to the traditional method, in which the patient did not play a role in the hand-off process. In some cases, the participation of family members boosted patient-nurse communication, which indicated satisfaction with the care delivery.

Although the study did not measure or focus on the HCAHPS scores, the ill persons' involvement, including the patients in the cardiac section, increased their confidence in the nurse-patient communication domain during the nurses' shift.

The BSR allowed the inclusion of patients, leading to higher HCAHPS scores in the patient-nurse communication facet than shift reports outside the room. Nurses transferring

information at the bedside allowed patients and family members to participate in the process, and according to Lozano and Marles (2015), this involvement increased awareness and reduced anxiety among the parties involved. On the other hand, Kullberg et al. (2017) concluded that a traditional hand-off denies patients and families opportunities to play an active role in keeping track of the medical processes, which leads to dissatisfaction with medical services. Thus, the BSR, which includes the patient's family members, facilitated communication between the parties, contrary to the traditional shift. As a result, in the cardiac unit, the BSR created an environment where communication between the parties was active and open. The BSR promoted patient and family participation and patient care planning, which fostered their experience while in the hospital.

The BSR established a collaborative and supportive environment between the nurse and the patient. The procedure also enhanced nurse and patient communication by empowering the patient to become engaged in their care through the art of communication. This factor is absent in traditional shift reporting. McAllen et al. (2018) conducted a study to determine the HCAHPS scores from nurse shift reports from conventional reporting to bedside shift reports. The authors showed that the BSR constituted a supportive, protective, and collective environment for the patients. The study concluded that this approach increased the HCAHPS scores in patient satisfaction in the patient-nurse communication domain.

Conversely, Cipra (2016) explained that the traditional NSR outside the patient room and the recording of information limited nurse-to-nurse and nurse-to-patient interactions, which increased the risk of miscommunication or misinterpretation. Thus, the BSR fostered collaboration and cooperation between nurses and patients, leading to patient satisfaction in nurse communication, contrary to the NSR completed outside the patient room with minimal

one-on-one interfaces. These findings were applied to every patient, including individuals with heart diseases. According to Douglas and Douglas (2014), the supportive environment also improved the patient experience, and research showed that according to patients, "a patient-friendly hospital is made by the staff being nice" (p. 65). To appear nice, the staff must interact with the patient, and that is where the BSR scored ahead of the formal NSR.

Dorvil (2018) showed that patients felt more informed about their care, which resulted in higher overall patient satisfaction in care delivery. Although the study did not focus on a specific domain, the communication with nurse dimension is the most affected aspect since patients rely on them to learn about their health conditions. On the other hand, Williams (2018) showed that traditional shift hand-offs affected the patients' experiences and caused dissatisfaction because the patients were less informed. Thus, the BSR has improved the patient-nurse communication dimension compared to reporting outside the room. The cardiac unit was affected in the same way as patients received quality attention from the nurses. Since the patients were informed, the BSR decreased miscommunication and medical errors.

Compared to the traditional reporting procedures, the BSR reduced miscommunication between nurses and their patients, leading to patient satisfaction in the nurse communication dimension. In their article, Vines et al. (2014) reported that NSR done verbally in another room excluded and denied patients an opportunity to participate or rectify miscommunicated information. The authors showed that some patients felt that errors occurred due to poor communication of the NSR.

Nevertheless, Nelson (2019) showed that the BSR adoption improved efficiency and eliminated communication errors evident in the traditional reporting technique. Since the BSR reduced miscommunication and subsequent medical errors, patients often attributed the

improvement to communication between them and the nurse. Therefore, although the two studies did not focus on the cardiac unit, these findings were applied to all medical groups. The BSR increased communication between healthcare providers. The BSR enhanced nurse-to-nurse communication, which enabled the nurses to provide patient-centered care that enhanced patient delivery experiences, leading to increased patient satisfaction.

Lozano and Marles (2015) stated that the BSR enabled nurses to observe a patient and confirm the outgoing nurse's information to obtain the assessment baseline for evaluating changes during the shift. Since the nurses had the correct information, they communicated with the patient the right way and asked focused questions. Conversely, Williams (2018) showed that reporting done in another room denied nurses the chance to assess and monitor the patient for effective care procedures. As a result, nurses sometimes asked patients irrelevant, vague, and general questions, which the ill persons often regarded as poor communication. In the cardiac unit, the BSR environment translated to higher patient satisfaction in the nurse-patient communication dimension. Besides planning and prioritizing patient care, the BSR eliminated the adverse outcomes caused by improper NSR.

The BSR fostered nurse-to-nurse communication, which allowed nurses to share updated information to deliver patient-centered services, which led to satisfaction compared to traditional techniques. Roslan and Lim (2017) showed that the BSR allowed the outgoing nurse to provide the incoming nurse with updated patient information and clarify unclear data, enabling nurses to plan patient care and ensure continuity of quality and satisfactory service. However, Vines et al. (2014) established that traditional reporting exercises, such as recording, hampered current patient information and increased the risk of misinterpretation of data. The findings demonstrated that the BSR supported the transfer of updated patient data to provide personalized

patient services. Although the studies did not specify the domain, patients, including those in the cardiac unit, attributed the improvement to various aspects of care, including the patient-nurse communication facet. In connection to the provision of patient-centered care, bedside shift reports promoted consistency in the quality of the care services.

Bedside shift hand-off minimized the variance in inpatient service quality, leading to satisfaction and high HCAHPS scores in the patient-nurse communication domain compared to reporting done outside the room. Greve (2017) explained that the bedside hand-off enabled the outgoing nurse to communicate patient information and share experiences encountered during the shift with the incoming nurse to ensure quality or standard patient care delivery. The author added that the procedure allowed the incoming nurse to access the patient's environment and plan patient care at the beginning of the shift. The consistent quality of care enhanced patient satisfaction and increased the HCAHPS scores in the nurse communication domain. Conversely, the nursing station's reporting had inconsistent quality due to limited interaction with the patient (Greve, 2017). Therefore, the BSR allowed nurses in all medical units to provide standardized services, and such a situation demonstrates effective communication among the nurses and between the nurses and patients as the patient confirms their conversation.

Search Limitations

The literature required further research for terms such as *bedside shift report(s)*, *shift report(s)*, *patient satisfaction*, and *HCAHPS scores*. Documentation showed that the BSR improved patient outcomes. However, the review required further research on this approach to patient satisfaction. The Abilene Christian University (ACU) Library OneSearch option was used to gather research. OneSearch populates articles from several databanks (EBSCO Host, PubMed, and Medline). Critical terms such as *bedside shift report(s), shift report(s), patient satisfaction*,

and the *HCAHPS scores* were searched. The feedback to conduct this was within the past 15 years, and 15,000 scores were displayed, allowing a vibrant collection of articles to complete this literature review.

Chapter Summary

Overall, the BSR increased patient satisfaction scores in the nurse communication dimension compared to traditional reporting methods. Various researchers stated that the procedure promoted a nurse-patient relationship, while others illustrated that it allowed patients to participate in the reporting process. The BSR also improved patient experience and satisfaction and minimized miscommunication between nurses. Additionally, the nurse-to-nurse shift hand-off next to the patient allowed for patient and family participation, enhancing confidence in nurse-patient communication. The BSR also reduced the miscommunication risks and fostered the transfer of updated patient information. The BSR ensured the delivery of standard quality of service and the creation of a safe and trusting environment. Therefore, bedside shift reporting increased patient satisfaction scores in the nurse communication dimension compared to the traditional reporting techniques.

Chapter 3: Methodology

Chapter 3 explains the methods used to design and implement this scholarly DNP project. The design provides justification and clear events and actions that shaped the project's development, accompanied by rationales. I will describe the type of research method in detail. The research study question was: For adult patients on a cardiac unit, does the BSR compared to shift reports at the nurses' station increase the HCAHPS scores for the communication with the nurse dimension?

Project Design

The literature search presented evidence that supported the BSR increased patient satisfaction. Evidence-based practice demonstrated that when shift reports were performed at the patient's bedside, nurse-patient communication increased (Reinbeck & Fitzsimons, 2013). Consequently, implementing the BSR as a practice guideline and policy fosters quality care that guarantees an increase in patient satisfaction and increases patient-nurse communication (Reinbeck & Fitzsimons, 2013). Patient satisfaction measures patients' perception of their hospital experience (Radtke, 2013; Vines et al., 2014). The HCAHPS is a survey instrument for measuring patients' perceptions of their hospital experience (Centers for Medicare and Medicaid Services, 2020).

The HCAHPS is the first national, standardized, publicly reported survey of the patients' perspectives of hospital care. The survey scores are examined and put up online for public reviewing (Health Consumer Assessment of Healthcare Providers and Systems [HCAHPS], 2020). The survey scores are effortlessly available online for the public to view and choose to inquire about healthcare services at a particular hospital. Public reporting survey scores sought to encourage hospitals to improve their consumer skills to provide quality healthcare (HCAHPS,

2020). Therefore, the organization's reputation is at risk. Furthermore, the government gives reimbursement based on scores, so exceptional survey performance enhances the hospital's sustainability.

The HCAHPS captured these experiences, such as communication with nurses. The project's purpose was to measure the effect of the BSR on the HCAHPS scores in the communication with nurse dimension. I analyzed the HCAHPS scores associated with the pre- and postimplementation of the BSR and patient satisfaction scores in the cardiac unit. In this case, the HCAHPS scores in communication with the nurse dimension were the instrument used to collect data from the research participants. I compared an 11-month preimplementation of the BSR HCAHPS score to an 11-month postimplementation. The BSR data examined had statistical significance and subsequent impact.

Instrument and Measurement Tool

Measuring patient-family satisfaction with care using a valid and reliable instrument is fundamental in understanding nursing care delivery and quality. The study used a supported, valid, and reliable tool to measure patient-family satisfaction to improve nursing care delivery and processes (Romero-Garcia et al., 2019). The HCAHPS is a nationally standardized, widely reported survey of the patients' perspectives of hospital care. The survey has a dimension that summarizes the patients' communication experiences with nurses. Patient satisfaction was measured using the HCAHPS scores. After discharge from the cardiac unit, patients received the HCAHP survey via four mechanisms: phone calls, mail, or a combination of mail surveys with a phone call. It took about eight minutes to complete the survey.

Data Collection, Management, and Analysis

The HCAHPS is a substantiated instrument jointly created by the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (Agency for Healthcare Research and Quality [AHRQ], 2013) to correctly measure the patient experience of healthcare quality in hospitals (Centers for Medicare and Medicaid Services, 2020). The HCAHPS was shown to be reliable and valid for assessing patient-centered care (Centers for Medicare and Medicaid Services, 2020).

According to the Centers for Medicare and Medicaid Services (2020), the HCAHPS quality assurance guidelines sampling employs the patient's principal diagnosis at discharge to determine eligibility for the HCAHPS: maternity care, medical, or surgical. Eligible patients were randomly selected and surveyed between 48 hours and six weeks after being discharged from the hospital (Centers for Medicare and Medicaid Services, 2020). Regardless of health insurance coverage, discharged patients were included in the study. They were 18 years of age at admission, alive at discharge, and stayed overnight in the hospital.

In April 2019, the NM of the cardiac unit granted permission to implement the project. Authorization was accomplished by directly telephoning the NM and discussing the project of interest. The project required educating the RNs on the BSR for two months, May and June 2019. Educating the nurses involved me, along with the clinical nurse educator. We were responsible for the nurse skill development to conduct the BSR. The NM from the transitional care unit was available to support the method. Team members revised the current shift reports process for the BSR to be successful. The BSR quality improvement project presented up-to-date resources to standardize end-of-shift reports that included patient engagement.

The NM of the cardiac unit discussed and displayed the unit's HCAHPS scores in the communication with the nurse dimension from April 2020 with the nursing staff and project implementation. The study compared HCAHPS scores in the communication with the nurse dimension preimplementation of the BSR from April 2020 (July 2018–June 2019 patient discharges) and scores postimplementation the BSR from April 2021 (July 2019–June 2020 patient discharges). Survey scores were posted on a dashboard in the nurse break room on the unit. Dashboards frame conversations, highlight exceptional work, reinforce performance improvement, and drive change (Piech et al., 2021).

The BSR was combined with verbal, nonverbal, and written methods of communication to transfer information to the patient-family during the report. Registered nurses used a nurse-patient worksheet to give and receive a nurse report from the incoming and outgoing nurses (see Appendix E). The nurse-patient worksheet standardized the BSR. The worksheet prompted the nurses on what patient data to include during the BSR. The NM of the cardiac unit posted the worksheets at the nurses' station and on the computer on wheels.

On the day of admission, the RNs instructed their patients on the BSR process. The BSR brochure (see Appendix D) described what it was and what role the patient would play in its process. The brochure was placed on the patient's whiteboard. All RNs who performed the BSR were responsible for updating whiteboards and receiving NSR at the patient's bedside. Using patient whiteboards is a cost-effective measure to incorporate patients in developing the patient care plan (Tobiano et al., 2018).

The BSR audit tool (see Appendix F) was implemented to confirm compliance in the process. This included validating the report was performed at the bedside, introducing the incoming nurse, using the nurse-patient worksheet, and updating the whiteboard. In addition, this

tool measured the beginning of the BSR until hand-off communication ended. The audit scores were shared monthly with the NM of the cardiac unit and RNs and provided data on which parts of the BSR the RN performed and omitted.

Appropriateness and Feasibility

At baseline, the NSR took place at the desk, in the hallways, or in a conference room. Subsequently, NSR nurses used several forms of written communication processes, and other units throughout the healthcare organizations used the standard the BSR. The continued decline in patient satisfaction scores made this study suitable and relevant for this clinical unit. Furthermore, the standard of care of the BSR is the best available EBP. Literature has suggested that the BSR enhances patient satisfaction in communication with nurses. In addition, professional registered nurses have a calling to care throughout a crisis like this pandemic. Nurses must serve when unfamiliar with a patient's needs and unusual clinical settings.

No sources of funding were established throughout implementing this DNP scholarly project. Therefore, this was a budget-neutral project as I led the EBP. I reviewed and delivered the supportive literature to the NM of the cardiac unit . The project was then implemented, and the change in process was evaluated. The benefits of project implementation to the patients, staff, the unit, and hospital outweighed the minimal financial cost associated with implementing the BSR, which is the travel expense to the project site.

Implementing the BSR improved quality care delivery and safety. Patients admitted to the cardiac unit were formally introduced to the BSR at the beginning of the admission process. In addition, the BSR brochure was on the patient's whiteboard and the times of occurrences to ensure the patient would be ready for full engagement in the process. Consequently, the BSR is part of the new hire training course. The clinical nurse educator provided biweekly training daily

for two months. The clinical nurse educator and I were familiar with the BSR. Therefore, we were responsible for unit training. The nurse used the BSR audit tool to assess compliance with standardized communication tools (see appendix F).

Institutional Review Board Process and Approval

Institutional review board (IRB) approval was necessary to implement the study. I requested IRB approval through Abilene Christian University (ACU; see Appendix G). Abilene Christian University granted permission for the project. An exemption was given after determining the research would involve minimal risk. The project contributed to the theoretical understanding of communication with nurses and patient satisfaction. I obtained consent from the NM to implement DNP scholarly project and use past and present survey scores and summarize these results (see Appendix H). Therefore, approval was given to summarize HCAHPS survey scores pre- and postimplementation of the BSR. The NM of the cardiac unit posted the HCAHPS scores on the bulletin board in the nurse's break room unit. The quality improvement research project gained scientific theories and explanations on the effect of the BSR on patient satisfaction with nurse communication.

Interdisciplinary Collaboration

Interprofessional collaboration refers to healthcare providers' ability from diverse fields and specializations to work together with families, patients, caregivers, and communities to deliver the highest quality care. According to Bosch and Mansell (2015), interprofessional collaboration is a crucial strategy for healthcare reforms and enhancing quality care services. According to Green and Johnson (2015), interprofessional collaboration "occurs when two or more professionals work together to achieve common goals and as a means for solving a variety of problems and complex issues" (Green & Johnson, 2015, p. 1). Collaboration between nurses

and other healthcare team members is vital because it ensures proper care and improved patient treatment outcomes.

The DNP scholarly project relied on collaboration with the clinical nurse educator, the NM of the cardiac unit, registered nurses, patient care assistants, and patients. The patient's families were excluded from the project due to a change in visiting policy due to COVID-19. The interprofessional partnership's primary goal was to establish a functional understanding of the impact of the BSR on patient satisfaction levels and to minimize miscommunication between patients and healthcare providers.

Practice Setting

The project implementation occurred in Louisiana at an over 20 cardiac bed unit in an over 200 bed community hospital. Registered nurses were in partnership with cardiologists and cardiovascular and cardiothoracic surgeons. The hospitalist managed patients with acute and chronic cardiac diseases and comorbidities. The nurse-patient ratio was one to five for the day shift day and one to six for the night shift. The assignment was based on ratio and patient acuity.

The unit handled telemetry patients. Some of the necessary diagnoses for patients receiving care in this unit included cardiac dysthymias, coronary artery disease, and myocardial infarction. Providing and facilitating care services to patients were physicians, registered nurses, patient care assistants, physician assistants, pharmacists, nurse practitioners, and physical or respiratory therapists. In addition, case managers, dietitians, and social workers were included in the interdisciplinary team. The patients admitted were also transferred from intensive care units, the emergency room department, and other hospitals in the surrounding area.

Target Population

The target population was patients ≥ 18 years that completed the HCAHPS survey discharged from the hospital from July 2018–June 2019 preimplementation of the BSR and patients discharged from July 2019–June 2020 postimplementation of the BSR. Eligible patients were randomly selected and surveyed between 48 hours and six weeks after discharge (Centers for Medicare and Medicaid Services, 2020). Discharged patients, regardless of forms of health insurance coverage, 18 years old when admitted, stayed overnight in the hospital, and were alive at discharge, were eligible to participate in the study. Families were excluded from the project due to changes in the visiting policy in response to COVID-19.

Risks and Benefits

As with most research studies, there were risks and benefits to implementing any research project. Within the project, justifications were provided regarding the limitation of risks to the human participants, reasonable risk according to the anticipated benefits, unbiased in selecting subjects, and informed consent to the respondent's other specifications. Therefore, risks in this study were minimal by utilizing a standard-of-care data collection instrument while collecting data. The BSR audit tool and the HCAHPS scores collected for this project did not have patient-sensitive information and maintained patients' anonymity who participated in the survey. The implementation of this project required the collection and analysis of the HCAHPS. This survey is a national, standardized instrument that measures the patient's experience while in the hospital. The government gives reimbursement based on scores, so exceptional survey performance enhances the hospital's sustainability.

Timeline

In January 2019, I received permission from the NM of the cardiac unit to implement the project. In February, I assembled a research team. The research team consisted of NM of this unit, the clinical nurse educator, and me. The project required educating the RNs on the BSR for two months. Training took place in May and June 2019. The baseline was collected for April 2020 (see Appendix I). The NM discussed and displayed the HCAHPS scores for the communication with nurse dimension preimplementation of the BSR from April 2020 (July 2018–June 2019 patient discharges) and scores postimplementation of the BSR from April 2021 (July 2019–June 2020 patient discharges). Thereafter, data was collected and analyzed (see Table 1).

Table 1

DNP Project Timeline

Date	Project Item
July 2019	Permission granted from the NM
August 2019	Research team assembled
September–October 2019	Best available EBP practices for NSR presented to nursing staff
November–December 2019	Project presented to other stakeholders
January–February 2020	Registered nurses trained in BSR process
March 2020	Audit of the BSR process for compliance
April 2020	HCAHPS survey scores–baseline data collected preimplementation BSR (July 2018–June 2019 patient discharges)
May 2020	BRS implemented
June 2020	BSR audit tool and other quality indicators utilized to ensure compliance to process
April 2021	HCAHPS survey scores collected postimplementation of BSR (July 2019–June 2020 patient discharges)
June 2021	Meeting held with relevant stakeholders to discuss results
July–Present	Quality indicator markers implemented to ensure BSR sustainability

Chapter Summary

The project used quantitative approaches to establish a correlation between the BSR and patient satisfaction in communication with the nurse. The methodology used the HCAHPS survey to assess patient satisfaction levels with services nurses provided in communication. The research team collected and analyzed data using a quantitative method to validate the BSR on patient satisfaction in nurse-patient communication compared to the NSR outside the patient's room. Notably, the study and methods used were foundations for understanding how clients' perceptions of their hospital experience can improve quality performance quality measures in primary care practices in hospitals.

Chapter 4: Findings

Chapter 4 explains the findings gathered from the data collection and analysis of this scholarly Doctor of Nursing Practice project. Provided is a comprehensive discussion of the results collected from the research methods. I describe the project's purpose to offer context of the applicability and importance of the BSR as an EBP for hospitals. I explain and justify the rationales used in selecting the data collection methods, the demographic patterns, and data analysis methods. I also justify and explain the questions guiding the inquiry on the problem of interest in the study. I offer a discussion that explains the rationale used in the reliability and validity test conducted in the study. The section ends with a summary that presents an overview of the project's findings.

Purpose of the Project

This Doctor of Nursing Practice scholarly project intended to gain a comprehensive understanding of the delivery of nursing care through communication and patient satisfaction. The project assessed changes in HCAHPS scores by examining four questions exploring communication with the nurse dimension and changes in these scores' preimplementation and postimplementation of the BSR. The BSR is an EBP introduced to the health care system to solve miscommunication affecting the quality of care delivery with the traditional NSR approach. The study employed quantitative data collection methods to gather information about the BSRs practice effectiveness. The primary data collection tools were the HCAHPS surveys and the nurse-patient worksheets. The study analyzed the HCAHPS survey in nurse communication containing eight specific questions subdivided into two categories. Four questions examined patients' experiences in communication with the nursing dimension before implementing the BSR, and the same four questions examined experiences after implementing

the BSR. The HCAHPS survey was administered by phone, email, or combining both mail and phone calls to gather information from the survey respondents. The nurse-patient worksheets were used as a data collection method for exchanging information between incoming and outgoing nurses during shift changes to facilitate the implementation and testing of the efficiency of the BSR. The worksheets created a standardized format that created a systematic care delivery system that allowed the hospital to track the progress of the BSR practice. The worksheets also facilitated patient-centered care by enabling patients to answer questions and track the quality of care during the nurses' shifts transition. Families of patients also benefited as they listened to patient information provided by nurses and contributed to data collection by offering their thoughts and suggestions about the BSR process. Information collected from the nurse-patient worksheets was also recorded on computers, which allowed for tracking the efficiency of the BSR practice. The study also utilized the patient's whiteboard, which allowed nurses to engage patients in the process and monitor its ability to drive change and promote quality care delivery.

The study used secondary data analysis. I explored 25 articles in the literature review section that comprehensively analyzed the BSR within the health sector. The participants used in the study were adult patients 18 years and older formerly admitted to the cardiac unit in the over 200 bed community hospital in Louisiana. Patients were randomly selected. The study used actual patients as participants because they had experience with the hospital's quality care. The study also used patients because they fit in as the appropriate target group, given the study's aim was to test the effect of the BSR on patient satisfaction with nurse communication (Watts et al., 2021).

Discussion of Demographics

The target population used to conduct the study were patients admitted to the over 20-cardiac bed unit in the over 200-bed community hospital in Louisiana. The study did not consider demographic characteristics such as gender, nationality, health insurance coverage, and type of disease or illness. The main factors for eligibility were age, duration after discharge, living status, admission, and duration of hospitalization (see Table 2). All participants selected for the study were 18 years and older, alive, and admitted for at least a night in the hospital. Participants were also chosen 48 hours to six weeks after discharge. The study was also limited to patients discharged from the hospital between July 2018 to June 2019 before implementing the BSR and patients released from July 2019 to June 2020 after implementing the BSR.

Table 2

Demographic Data

Characteristic	Requirement
Age	18 years and older
Duration after discharge	48 hours to six weeks
Living status	Alive
Admission	At least one night stay
Duration of hospitalization	July 2018–June 2019
	July 2019–June 2020

Data Analysis

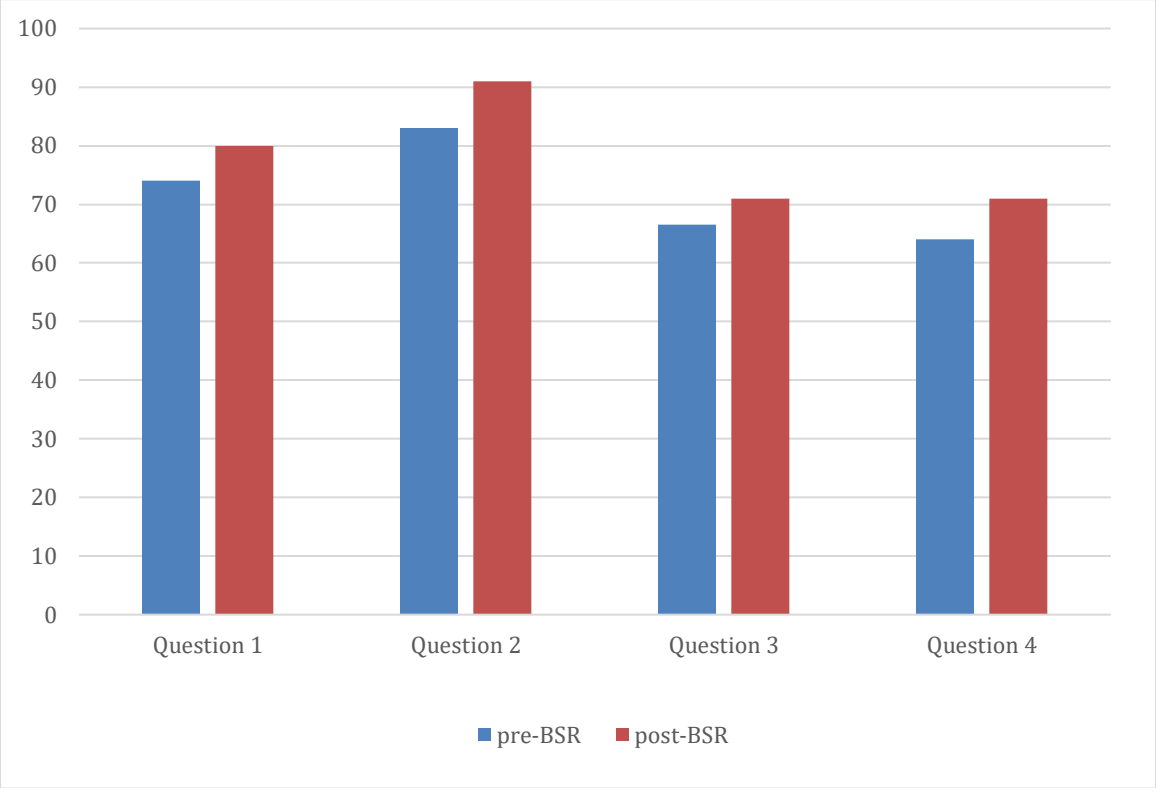
The study used two primary data analysis tools to evaluate the survey results. The study used longitudinal data analysis and benchmarking. Longitudinal data analysis allowed me to

assess the changes in scores compared over time before and after implementing the program (Garcia & Marder, 2017). The study also carried out benchmarking to analyze the difference scores compared to other hospitals over the scope of 12 months from 2018 to 2020 (Ong & Roundy, 2020). Longitudinal data analysis and benchmarking methods were appropriate as they allowed for monitoring the changes and identifying the trends associated with the data. In the case of the study, data analysis revealed an upward trend in the findings. Question one results uncovered an upward trend in courtesy and respect afforded to patients by nurses.

The BSR implementation increased the percentages from 74% to 80%, implying improved service delivery as nurses were concerned about offering the best customer service to patients. Question two also revealed an upward trend after the implementation of the BSR. Patients recorded an increase in careful listening by nurses that rose from 83% to 91%. The result implied that this process facilitated patient-centered care as nurses allowed patients' active involvement in their care and treatment within the hospital. Question three also expressed a similar upward trend in the results gathered for the survey. The patients revealed that implementing this process improved the explanation provided by nurses from 66.5% to 71%. These results showed that better communication and a healthy nurse-patient relationship translated to improved quality service delivery (Kinney & Sankaranarayanan, 2021). Lastly, question four recorded the same results as patients reported that nurses had better responses to call buttons. The results expressed an upward trend that rose from 64% to 71% (see Figure 1).

Figure 1

HCAHPS Results Pre- and Post-BSR Implementation



The findings imply that the BSR improved quality service delivery as nurses was more concerned about ensuring they catered to their patients' needs and interests. Therefore, the longitudinal data analysis methods confirmed that BSR implementation improved communication with nursing dimensions (McDaniel et al., 2021). Longitudinal data analysis was appropriate as it allowed for comparative analysis of the changes in data over time. Longitudinal data analysis allowed for the comparative analysis of the quality of care and nursing communication provided to patients before and after BSR implementation. An upward trend in the score was an indication that the BSR improved the quality of care delivery within the health institution.

Question Guiding the Inquiry

The PICO question examined in this study was, for adult patients on a cardiac unit, does the BSR compared to the NSR completed outside the patients' rooms increase the HCAHPS survey scores for the communication with nurse dimension?

The study explored the PICO acronym as follows:

- Population: Adult patients in the cardiac unit
- Intervention: The BSR
- Comparison: The NSR was completed outside the patient's room
- Outcome: Increase the HCAHPS scores for the communication with nurse dimension.

The research included all PICO elements within its implementation. First, patients were randomly selected for the study. They were adult patients 18 years and older and were admitted to the cardiac unit at a 256-bed hospital in Louisiana. The intervention under testing within the research is the applicability and efficiency of the BSR technique as a method for reporting within the healthcare system. The study carried out a comparative analysis of the efficiency of BSR and the traditional NSR conducted outside the patient room to determine which method provided quality reporting in communication with the nurse dimension of the HCAHPS. Finally, the research study aimed to test whether the implementation of the BSR as an intervention resulted in an outcome that generates increased HCAHPS scores for the communication with nurse dimension. Based on the findings gathered by the study, the answer to the PICO question mentioned above is *yes*. Bedside shift report implementation increased the HCAHPS survey scores for nurse communication among adult patients in the cardiac unit compared to traditional NSR.

The longitudinal data analysis and benchmarking analysis helped evaluate the PICO questions by comparing the results of HCAHPS scores during the traditional NSR program and after implementing the BSR program (Roberts et al., 2021). The findings revealed an upward trend in the HCAHPS scores after introducing the BSR program. Therefore, the data implied that the BSR increased the HCAHPS scores for the communication with nurse dimensions. The data analysis revealed that BSR is a credible intervention to replace the traditional NSR practice conducted outside the patient's room as it was successful in increasing HCAHPS scores.

Reliability and Validity

This research is reliable and valid as it complied with required experimental concepts and scientific research methods. The study had a focused purpose that involved providing a feasible solution to an existing problem in the healthcare sector. The BSR offered a solution to the miscommunication, which caused a decrease in the quality of care delivery within the traditional NSR system. The DNP scholarly project aimed to assess the effect of the BSR on patient satisfaction in care delivery for communication with nurse dimensions in the HCAHPS. The study is valid because it used accurate and reliable measurement procedures. The study used HCAHPS surveys that were valid and reliable, created by credible health organizations such as Medicare, Medicaid, and the Agency for Healthcare Research and Quality (AHRQ, 2013; Chen et al., 2020). The study also had a literature review section exploring 25 articles created by experts and credible authors based on valid research studies on implementing BSR in hospitals.

The study also used a valid target population and practice setting for the experiment. The participants were adult patients who voluntarily agreed to participate in the study. The choice of participants was valid because they experienced the type of quality service provided at a

Louisiana hospital and can offer credible firsthand accounts in answering the HCAHPS survey questions.

Although the participants were selected from the cardiac unit, the research findings remain valid because the sample can serve as a general representation of the type of care and communication with the nurse dimension provided within the institution and the public medical sector. The study was also implemented at a community hospital in Louisiana and was performed in partnership with registered nurses, cardiologists, and cardiovascular and cardiothoracic surgeons who are reliable experts in this multifaceted healthcare business. The study was valid and dependable as it was conducted in compliance with IRB processes and approval from Abilene Christian University. The study was reliable and accurate as it complied with IRB processes and permission from Abilene Christian University.

Chapter Summary

The study assessed the impact of the BSR on patient satisfaction in care delivery for communication with nurse dimensions in the HCAHPS scores. The findings of the HCAHPS survey revealed an upward trend in various concepts measured within the HCAHPS score, including courtesy and respect, listening, communication with patients, and response to patients' needs indicating improvement in care delivery (Aoki et al., 2020). The findings revealed that the BSR increased the survey scores, implying better patient satisfaction and improved care delivery due to enhanced communication between patients and nurses and among nurses providing care. The findings confirmed that the BSR implementation offered a positive result for the PICO question. Therefore, it serves as a suitable intervention for replacing traditional NSR practices. The findings also revealed that the study is reliable and valid as it complied with scientific and

experimental research requirements by using appropriate methods, the IBR process, and approval.

Chapter 5: Discussion of Findings

Chapter 5 provides a summary and comprehensive analysis of the findings and the information presented within the literature of the scholarly DNP project. I discuss and explain the lessons learned and how nursing leaders can resourcefully use the results to improve their professional competencies. I offer a comprehensive data analysis of the discussion in the DNP project by addressing various topics. First, I interpret and infer the findings by exploring the research question and discussing new knowledge on existing nursing research. I discuss the implication of the analysis for leaders in the nursing industry and its relationship to the eight DNP essentials. I explore future recommendations by discussing the relevance of the research in improving practice, education, and policy in the nursing industry. The section ends with a summary that presents an overview of the discussions presented about the findings.

Interpretation and Inference of Findings

This DNP scholarly research aimed to understand better the delivery of nursing care through communication and patient satisfaction. The project assessed the impact of the BSR on patient satisfaction within communication with nurse dimensions by exploring the changes in HCAHPS scores. The main research question was whether the BSR increased HCAHPS survey scores for communication with nurse dimension compared to traditional NSRs for adult patients in the cardiac unit (Rodriguez-Homs et al., 2020). The study's findings answered the research question by revealing that implementing the BSR increased the HCAHPS survey scores for communication with nurse dimension compared to NSRs. The findings of the HCAHPS survey revealed an upward trend in various concepts measured within the HCAHPS scores as follows: courtesy and respect increased by 6%, careful listening increased by 8%, comprehensive explanation increased by 4.5%, and response to call buttons increased by 7%. These results

confirmed that the BSR is a suitable intervention for replacing traditional NSR practices. The BSR increased patient satisfaction and improved care delivery due to enhanced communication between patients and nurses and among nurses providing care.

Current data on the BSR nursing interventions revealed that traditional NSR practices are unreliable due to constant interruptions and disruptions from patients, families, and the hospital environment. Unfortunately, these NSR practices contribute to miscommunication, the leading cause of malpractice. The NSR results in deaths and injuries and accounts for $2.9 billion in annual spending on malpractice compensation in the U.S. healthcare sector. This study confirmed that BSR offered a solution to NSR miscommunication problems, serving as a suitable alternative to replace the traditional NSR practice (Dorvil, 2018). The project's findings revealed that the BSR implementation helped nurses develop rapport and better nurse-patient relationships. Therefore, the BSR improved nurses' professional competency by facilitating patient-centered care through open communication with patients about treatment plans, which actively improved their receptiveness during the treatment process. The BSR also facilitated communication between nurses and patients' family members. It encouraged communication among nurses through the exchange of reports between offgoing and incoming nurses attending to patients (Abor, 2019). The findings also revealed that the BSR improved nurses' professional responsibility and accountability. The process had a standardized data collection system for authenticating patient health history records, medical evaluations, diagnosis, treatment, care plans, and discharge records. It helped nurses reduce unplanned overtime during their shifts, which helped improve their work-life balance and professional competency.

The DNP project applied Lewin's three-step model of change management as the theoretical framework for evaluating the effectiveness of the BSR system. The framework served

as a competitive strategy for promoting positive outcomes of the BSR and offering formal training to nurse managers and executives (Scheidenhelm & Reitz, 2017). Lewin's change theory model has three stages. First is the unfreezing stage, where the organization identifies a problem or gap that calls for change. During this stage, the organization prepared for change by educating and persuading people to accept the change. For the DNP project, the change involved implementing the BSR system. Before developing a framework for implementation, I created awareness during formal meetings to educate stakeholders to acquire approval of the project. The DNP project identified that traditional NSR practices were unreliable as they caused problems such as miscommunication, which resulted in death and billions of losses in malpractice claims.

Traditional NSRs also contributed to the low HCAHPS scores for communication with the nurse dimension, creating the need for change (Dorvil, 2018). The research team discovered that the BSR offered a solution to the miscommunication. Apart from educating and persuading the stakeholders and nurses to approve implementing the BSR system during meetings, the research also focused on psychologically preparing the patients for change. Patients received brochures on their whiteboards to educate them on the importance and effectiveness of BSR in improving communication in the nurse dimension within the HCAHPS scores.

The second step of Lewin's change theory is the change. The phase involved implementing the changes. For the DNP project, implementation of change involved putting in place the BSR system. The BSR system requires registered nurses to conduct patient bedside shift reporting by using a standardized nurse-patient worksheet that allows off-going and incoming nurses to exchange information before beginning their shifts. The final stage is the refreezing stage, which involves continuous monitoring of changes to ensure complete interception into the organizational system. The research team tracked BSR activities conducted

by registered nurses. The BSR audit tool and performance indicators were used to ensure compliance with the BSR requirements (Harrison et al., 2021).

Implication Analysis for Leaders

The DNP scholarly project presented resourceful information instrumental to improving current nursing leadership care competencies. According to the findings, the BSR system offered a suitable intervention for handling the gaps associated with traditional NSR practice, such as miscommunication, deaths caused by malpractice, and losses from malpractice claims. The BSR also helped improve the HCAHPS scores for communication with the nursing dimension, which increased patient satisfaction due to improving the quality of care delivery. Therefore, the project's findings are crucial for nursing leadership care as they offered solutions to improve nursing competencies that are instrumental in promoting patient satisfaction and quality care delivery. The findings of the DNP project also provided enlightening ideas on how to improve nursing, community, and current healthcare. The BSR improved nursing competencies by increasing accountability, reducing unplanned overtime, and promoting open communication between nurses, improving the quality of care delivery (Tacchini-Jacquier et al., 2020). It also encourages community by facilitating the development of rapport and stable patient-nurse relationships, which improve patient participation in the treatment (Harrison et al., 2021). The BSR improves current healthcare systems by facilitating patient-centered care, which promotes patient satisfaction. Therefore, the DNP project recommends that nursing leaders approve and promote the implementation of BSR within the nursing practice and health institution. The nursing leaders should adopt the BSR as an effective intervention to replace the unreliable traditional NSR practice. The primary similarity between NSR and BSR is that they both report

and track nursing competencies. However, nursing leaders should adopt the BSR to facilitate patient-centered care that improves patient satisfaction and treatment competencies.

Essential I: Scientific Underpinnings for Practice

Miscommunication is a primary professional and ethical concern for practitioners in the healthcare industry. Miscommunication is the leading cause of unnecessary errors that result in deaths, injuries, and financial losses from malpractice claims. Fortunately, literature has provided support that using the BSR as an alternative to the NSR helps solve the problem of miscommunication as it facilitates open communication among nurses and the development of a patient-centered care system (Abor, 2019). Literature also revealed that implementing the BSR increased HCAHPS scores for communication with the nursing dimensions, which promoted patient satisfaction due to improved care delivery (Abor, 2019).

Lewin's three-step model of change management was the theoretical framework applied in the project. The theory helped guide and educate nurse managers, executives, registered nurses, and patients on the importance and effectiveness of BSR in solving NSR problems to promote approval and receptiveness to change. As a DNP graduate, I believe that implementing scientific knowledge and evidence-based scientific guidelines within the clinical practice helped create competent nurse scientists who will improve the quality-of-care delivery within the healthcare system.

Essential II: Organizational and Systems Leadership for Quality Improvement and Systems Thinking

According to the Doctor of Nursing Practice (2021), "The DNP project provided information that is instrumental to improving nursing science, as the findings can be disseminated and implemented into practice within the healthcare industry" (p. 8). The findings

confirmed that BSR offered a suitable alternative to NSR and recommended its implementation to improve the quality of care delivered and the healthcare sector's overall performance (Jimmerson et al., 2021). The information presented in the findings is also instrumental for improving leadership and quality improvement of patient outcomes within the healthcare sector. The BSR improved professional leadership in the healthcare industry as it facilitated training and improved accountability among nurse managers and registered nurses. The BSR also improved the quality of patient outcomes by facilitating open communication among nurses, patient-centered care systems, and the development of a stable patient-nurse relationship that encourage patients' active involvement in treatment options. The BSR enhanced systems thinking as it is a designed evidence-based intervention that improved the competency of nurses due to increased accountability and policy development, which promoted change and improved service delivery within healthcare systems.

Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice

As a DNP graduate, "the project presented an opportunity to conduct empirical research within a clinical setting using analytical methods for evidence-based practice to offer practical change and solutions to complex issues facing modern healthcare" (Doctor of Nursing Practice, 2021, p. 11). The project conducted a gap analysis and discovered that traditional NSR practice was unreliable as it experienced challenges such as miscommunication, unnecessary deaths, injuries, and financial losses from malpractice claims (Jimmerson et al., 2021). Fortunately, literature from clinical scholarship revealed that the BSR offers an intervention that helps to solve NSR challenges. The DNP project allowed DNP graduates to disseminate information crucial for improving competencies within the healthcare sector. Applying the BSR practice

within the nursing sector assures accountability of quality care, patient satisfaction, ethical standards, and scientific research.

Essential IV: Information Systems and Technology and Patient Care Technology for the Improvement and Transformation of Health Care

"The DNP project allowed DNP graduates to use information systems and patient care technology to improve the nursing profession's competencies and promote development within the healthcare sector" (Doctor of Nursing Practice, 2021, p. 12). The literature confirmed the need to implement BSR to enhance and transform healthcare systems. The BSR promoted information management skills and improved healthcare by facilitating increased accountability and open communication between practitioners and patients (Fon et al., 2021). Therefore, it improved patient satisfaction and promoted positive outcomes within healthcare systems. The BSR also used information systems to create a patient-centered care system that encouraged the inclusive participation of patients within the treatment process. The BSR employed patient care technology to create a standardized method for providing care within the healthcare system.

Essential V: Health Care Policy for Advocacy in Health Care

The DNP project allowed DNP students to develop the understanding and knowledge required to create healthcare policies for improving competencies within the healthcare sector. The literature provided DNP students with information about the BSR and explored the efficiency of its implementation in improving outcomes in the healthcare sector. The findings revealed that the BSR is an essential healthcare policy that will facilitate open communication, improved accountability, and the creation of patient-centered care systems (Small & Fitzpatrick, 2017). The BSR also promoted advocacy in the healthcare sector by promoting equity in healthcare institutions' access and provision of quality care delivery and treatment.

Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes

The DNP project allowed DNP graduates an opportunity to engage in actual practice within the clinical setting and network with healthcare professionals to improve healthcare outcomes. The literature revealed that the project involved interdisciplinary collaboration between students and healthcare professionals such as registered nurses, nurse managers from the cardiac and transitional care unit, clinical nurse educators, patients, patient care assistants, patient families, and communities. The DNP project also involved implementing a BSR system that encourages interprofessional collaboration between NMs, RNs, and other medical practitioners in providing care for patients to improve care delivery services and population health outcomes (Wang & Gibbs, 2019).

Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health

"The DNP project allowed DNP students to develop strategies for using evidence-based practice to develop solutions for clinical prevention of healthcare problems such as miscommunication, deaths, and malpractice risks to promote population health and improve the nation's healthcare system" (Doctor of Nursing Practice, 2021, p. 15). The literature explored the BSR strategy that served as clinical prevention that solves miscommunication, deaths, and malpractice problems associated with the traditional NSR practice (Small & Fitzpatrick, 2017). The BSR also explored the ethical and legal concerns affecting the healthcare communities and created a patient-centered care system that improves the competencies of nurses and nation healthcare outcomes (Leon-Villapalos et al., 2020).

Essential VIII: Advanced Nursing Practice

The DNP project allowed DNP graduates to conduct practice within the clinical setting, which helped them learn how to apply their knowledge to advance their leadership capabilities and professional specialization within the highly competitive healthcare system. The DNP project allowed the student to learn how to design and implement the BSR as an evidence-based intervention for clinical prevention of traditional NSR shortcomings to enhance the population's healthcare outcomes (Dorvil, 2018). The literature revealed that the BSR promotes the development of patient-centered care systems and stable nurse-patient relationships that help to improve healthcare outcomes for patients, families, and communities, thus improving national healthcare.

Recommendations for Future Research

Miscommunication is a primary ethical and professional concern for healthcare providers due to associated deaths, injuries, and financial losses from malpractice claims. The traditional NSR system was unreliable in resolving this problem as it faced numerous communication disruptions (Small & Fitzpatrick, 2017). Fortunately, healthcare practitioners discovered that the BSR offers a suitable alternative that solves all traditional NSR system miscommunication problems (Fon et al., 2021). Therefore, there is a need to incorporate the BSR system in designing and implementing healthcare policies across healthcare institutions worldwide to improve healthcare competencies. The DNP project provides DNP graduates with adequate information and knowledge to design and implement healthcare policies and policy controls for incorporating BSR systems within healthcare service delivery in health institutions.

As mentioned, the literature confirmed that the BSR is a suitable alternative for the traditional NSR systems. Practice recommendations include:

1. Health institutions should increase funds and investment for research and development of the BSR intervention to improve the quality of care within healthcare institutions.
2. The health sector should conduct research using a more extensive and diverse sample population, including mobile clinics, the informal care sector, and hospitals in marginalized communities, to provide a comprehensive evaluation of the efficiency of the BSR within the national healthcare system.

Recommendations for Policies

Literature showed the need to develop policies for designing and implementing BSR systems within healthcare facilities and the national healthcare system. The recommendations are as follows:

1. The healthcare administrators should set up a national healthcare access task force to design and implement national healthcare policies requiring mandatory BSR in healthcare organizations.
2. Health sectors should adopt and incorporate new digital technologies to facilitate developing strategies and policies for the ethical framework, governance, and regulations for implementing BSR systems.
3. Health institutions should create and implement quality measurements for tracking metrics and patient-reported outcome measures to assess the performance of the BSR.

Recommendations for Education

The DNP project serves as a resourceful learning experience that allows DNP graduates to apply knowledge taught in class to the practical clinical environment. The recommendation for education includes:

1. The nursing administrators should create a national culture of learning within the healthcare sector to smooth the process of redesigning and implementing the BSR in healthcare (Jimmerson et al., 2021).
2. Health institutions should adopt and incorporate healthcare analytics in evaluating data from the BSR systems.
3. Health institutions should connect and collaborate with other healthcare organizations to conduct research and develop education forums for learning about the BSR systems.

Conclusion

The DNP project offered resourceful information about implementing BSR systems as an alternative to the traditional NSR systems. This DNP scholarly research aimed to understand better the delivery of nursing care through communication and patient satisfaction. The findings revealed that the BSR served as a suitable alternative for the traditional NSR system as it helped solve miscommunication problems that cause death, injury, and financial losses due to malpractice claims in the healthcare industry. The findings also revealed that the BSR improved patient satisfaction and care delivery due to enhanced communication between patients and nurses and among nurses providing care. The results showed that the BSR increases HCAHPS scores for communication with the nursing dimension, improving healthcare delivery services in health institutions.

I recommend increasing investments, extensive research, the creation of a national task force, incorporation of digital technologies, quality measurements, and a culture of learning. I also encourage conducting health analytics and collaboration with other health institutions to implement the BSR strategies and policies within the healthcare system effectively. The

literature confirmed that the BSR offers a suitable alternative that solves the miscommunication problems of the traditional NSR. Therefore, the action plan involves designing, developing, and implementing BSR policies and policy controls within the healthcare sector.

References

Abor, P. A. (2019). Exploring clinical communication in a teaching hospital in Ghana. *International Journal of Health Governance*, *24*(2), 155–168. https://www.emerald.com/insight/content/doi/10.1108/IJHG-10-2018-0058/full/html

Agency for Healthcare Research and Quality. (2013). *Nurse bedside shift reports: Implementation handbook*. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy3/Strat3_Implement_Hndbook_508.pdf

Aoki, T., Yamamoto, Y., & Nakata, T. (2020). Translation, adaptation and validation of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for use in Japan: A multicentre cross-sectional study. *BMJ Open*, *10*(11), 1–7. https://bmjopen.bmj.com/content/bmjopen/10/11/e040240.full.pdf

Baker, S. J. (2010). Bedside shift reports improve patient safety and nurse accountability. *Journal of Emergency Nursing*, *36*(4), 355–358. https://pubmed.ncbi.nlm.nih.gov/20624574/

Bosch, B., & Mansell, H. (2015). Interprofessional collaboration in healthcare. *Canadian Pharmacists Journal*, *148*(4), 176–179. https://doi.org/10.1177%2F1715163515588106

Bressan, V., Cadorin, L., Stevanin, S., & Palese, A. (2019). Patients experiences of bedside hand-off: Findings from a meta-synthesis. *Scandinavian Journal of Caring Sciences*, *33*(3), 556–568. https://doi.org/10.1111/scs.12673

Caruso, E. M. (2007). The evolution of nurse-to-nurse bedside reports on a medical-surgical cardiology unit. *Medsurg Nursing*, *16*(1), 17–22. https://pubmed.ncbi.nlm.nih.gov/17441625/

Centers for Medicare and Medicaid Services. (2020). *Hospital CAHPS (HCAHPS)*. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/HCAHPS1

Chen, H. C., Cates, T., Taylor, M., & Cates, C. (2020). Improving the US hospital reimbursement: How patient satisfaction in HCAHPS reflects lower readmission. *International Journal of Health Care Quality Assurance*, *33*(4/5), 333–344. https://doi.org/10.1108/IJHCQA-03-2019-0066

Cipra, E. J. (2016). *The move from recorded to bedside shift reports: Evaluating barriers to full implementation* [Doctoral dissertation, Walden University]. Walden Dissertations and Doctoral Studies. https://scholarworks.waldenu.edu/dissertations/2023/

Clark, K., Milner, K., Marlene, B., & Mason, V. (2016). Measuring family satisfaction with care delivered in the intensive care unit. *Critical Care Nurse*, *36*(6), 9–14. https://doi.org/10.4037/ccn2016276

Doctor of Nursing Practice. (2021). *What is a DNP*? https://www.doctorofnursingpracticednp.org/what-is-a-dnp/

Dorvil, B. (2018). The secrets to successful nurse bedside shift reports implementation and sustainability. *Nursing Management*, *49*(6), 20–40. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5976230/

Douglas, C. H., & Douglas, M. R. (2014). Patient-friendly hospital environments: Exploring the patients' perspective. *Health Expectations*, *7*(1), 61–73. https://pubmed.ncbi.nlm.nih.gov/14982500/

Elue, R., Simonvich, S. D., Tariman, J. D., Newkirk, E. A., & Neerhof, M. (2020). Bedside shift report enhances patient satisfaction for Hispanic and public insurance patients and improves visibility of leadership in obstetrics and postpartum setting. *Journal of Nursing Practice Applications and Reviews of Research*, *9*(2), 4–11. https://doi.org/10.13178/jnparr.2019.09.02.0903

Evans, D., Grunawait, J., McClish, D., Wood, W., & Friese, C. R. (2012). Bedside shift-to-shift nursing report: Implementation and outcomes. *Medsurg Nursing*, *21*(5), 281–292. https://pubmed.ncbi.nlm.nih.gov/23243785/

Fon, K., Elsabrout, K., Piken, N., Wood, D., Dusseldorp, E., & McMahon, L. A. (2021). An interprofessional length of stay reduction: A process improvement project. *Nursing Economics*, *39*(1), 5–14, 22. https://www.proquest.com/openview/156d5da5aed52a0848bba94dec2a9683/1?pq-origsite=gscholar&cbl=30765

Foster, C. L., Abraham, S. P., & Gillum, D. R. (2019). Emergency room nurses' views on bedside shift reporting. *International Journal of Studies in Nursing*, *4*(4), 55–69. http://journal.julypress.com/index.php/ijsn/article/view/677/493

Galehdar, N., Toulabi, T., Kamran, A., & Heydari, H. (2020). Exploring nurses' perception about the care needs of patients COVID-19: A qualitative study. *BMC Nursing*, *19*(1), 1–8. https://doi.org/10.1186/s12912-020-00516-9

Garcia, T., & Marder, K. (2017, October 9). Statistical approaches to longitudinal data analysis in neurodegenerative diseases: Huntington's disease as a model. *Current Neurology and Neuroscience Reports*, *17*(2), 14. https://pubmed.ncbi.nlm.nih.gov/28229396/

Goldfarb, M., Bibas, L., Bartlett, H., Jones, H., & Kahn, N. (2017). Outcomes of patient and family-centered care interventions in the ICU: A systematic review and meta-analysis. *Critical Care Medical*, *45*(10), 1751–1761. https://doi.org/10.1097/CCM.0000000000002624

Green, B. N., & Johnson, C. D. (2015). Interprofessional collaboration in research, education, and clinical practice: Working together for a better future. *Journal of Chiropractic Education*, *29*(1), 1–10. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4360764/pdf/i1042-5055-29-1-1.pdf

Greve, R. (2017). *Implementation of patient-centered bedside report to increase patient and staff satisfaction* [Doctoral dissertation, University of Maryland, Baltimore]. https://archive.hshsl.umaryland.edu/handle/10713/7768

Halm, M. A. (2013). Nursing handoffs: Ensuring safe passage for patients. *American Journal of Critical Care*, *22*(2), 158–162. https://doi.org/10.4037/ajcc2013454

Harrison, R., Fischer, S., Walpola, R. L., Chauhan, A., Babalola, T., Mears, S., & Le-Dao, H. (2021). Where do models for change management, improvement and implementation meet? A systematic review of the applications of change management models in healthcare. *Journal of Healthcare Leadership, 13,* 85–108. https://doi.org/10.2147/JHL.S289176

Hospital Consumer Assessment of Healthcare Providers and Systems. (2020). *Current news*. Retrieved November 21, 2020, from https://hcahpsonline.org/en/

Jimmerson, J., Wright, P., Cowan, P. A., King-Jones, T., Beverly, C. J., & Curran, G. (2021). Bedside shift report: Nurses opinions based on their experiences. *Nursing Open*, *8*(3), 1393–1405. https://doi.org/10.1002%2Fnop2.755

Joint Commission. (2002). *National patient safety goals*. https://www.jointcommission.org/resources/news-and-multimedia/fact-sheets/facts-about-national-patient-safety-goals/

Khuan, L., & Juni, M. H. (2017). Nurses' opinions of patient involvement in relation to patient-centered care during bedside handoffs. *Asian Nursing Research*, *11*(3), 216–222. https://doi.org/10.1016/j.anr.2017.08.001

Kinney, A. P., & Sankaranarayanan, B. (2021). Effects of patient portal use on patient satisfaction: Survey and partial least squares analysis. *Journal of Medical Internet Research*, *23*(8), e19820. https://www.jmir.org/2021/8/e19820

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.) (2000). *To err is human: Building a safer health system*. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK225182/

Kullberg, A., Sharp, L., Johansson, H., Brandberg, Y., & Bergenmar, M. (2017). Patient satisfaction after implementation of person-centered hand-off in oncological inpatient care: A cross-sectional study. *PLOS One*, *12*(4), 1–14. https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0175397&type=printable

Kumah, E. (2019). Patient experience and satisfaction with a healthcare system: Connecting the dots. *International Journal of Healthcare Management*, *12*(3), 173–179. https://doi.org/10.1080/20479700.2017.1353776

Leon-Villapalos, C., Wells, M., & Brett, S. (2020). Exploratory study of staff perceptions of shift safety in the critical care unit and routinely available data on workforce, patient and

organisational factors. *BMJ Open*, *10*(6), 1–9. https://bmjopen.bmj.com/content/bmjopen/10/6/e034101.full.pdf

Lozano, M. G., & Marles, L. P. A. (2015). The hand-off: A central concept in nursing care. *Enfermería Global*, *14*(1), 419–430. https://scielo.isciii.es/pdf/eg/v14n37/en_revision3.pdf

Malfait, S., Hecke, A. V., Biesen, W. V., & Eckloo, K. (2019). A systematic review of patient participation during bedside hand-offs onwards with older patients indicates evidence is urgently needed. *International Journal of Older People Nursing*, *14*(2), e12226. http://doi.org/10.1111/opn.12226

McAllen, E. R., Stephens, K., Swanson-Biearman, B., Kerr, K., & Whiteman, K. (2018). Moving shift reports to the bedside: An evidence-based quality improvement project. *Online Journal of Issues in Nursing*, *23*(2), 1–25. https://doi.org/10.3912/OJIN.Vol23No02PPT22

McDaniel, C., Caspersen, A., Crumpton, S., Galbraith, D., Hall, B., Huddleston, P., Nguyen, H. L., Puckett, M., & Williams, R. (2021). Medical-surgical patients' and registered nurses' satisfaction and comprehensiveness of patient assessment using the clinically aligned pain assessment tool. *Pain Management Nursing, 21*, 190–199. https://doi.org/10.1016/j.pmn.2021.08.003

National Practitioner Data Bank. (2012). *Adverse action and medical malpractice reports (1990–2011)*. https://www.npdb.hrsa.gov/index.jsp

Nelson, M. M. A. (2019). *Utilization of bedside shift reports to decrease medication errors on a cardiac progressive care unit* [Doctoral dissertation, Abilene Christian University].

Margarett & Herman Brown Library Digital Commons. https://digitalcommons.acu.edu/etd/172/

Ong, H., & Roundy, P. E. (2020). The compressional beta effect: Analytical solution, numerical benchmark, and data analysis. *Journal of the Atmospheric Sciences*, *77*(11), 3721–3732. https://doi.org/10.1175/JAS-D-20-0124.1

Piech, L. K., Burke, C., & Johansen, M. L. (2021). Dashboards and report cards: Using staff performance to drive outcomes. *Nursing Management*, *52*(3), 10–13. https://doi.org/10.1097/01.numa.0000733660.62672.8e

Prosser, D. M., Andrews, D., & Wheatley, C. (2020). Improving communication of the plan of care in the acute care setting. *Nurse Leader*, *18*(4), 364–369. https://doi.org/10.1016/j.mnl.2019.05.014

Radtke, K. (2013). Improving patient satisfaction with nursing communication using bedside shift reports. *Clinical Nurse Specialist*, *27*(1), 19–25. https://doi.org/10.1097/nur.0b013e3182777011

Reimer, J. (2021). The new normal-corona and the church. *European Journal of Theology*, *30*(1), 1–6. https://doi.org/10.5117/EJT2021.1.001.REIM

Reinbeck, D. M., & Fitzsimons, V. (2013). Improving the patient experience through bedside shift reports. *Nursing Management*, *44*(2), 16–17. https://doi.org/10.1097/01.NUMA.0000426141.68409.00

Riesenberg, L. A., Leitzsch, J., & Little, B. W. (2009). A systematic review of hand-off mnemonics literature. *American Journal of Medical Quality*, *24*(3), 196–204. https://pubmed.ncbi.nlm.nih.gov/19269930/

Rifai, A., Afandi, A. T., & Hasanah, A. (2020). Bedside nursing handover: Patient's perspective. *NurseLine Journal*, *4*(2), 123–130. https://doi.org/10.19184/nlj.v4i2.15422

Roberts, B. W., Roberts, M. B., Mazzarelli, A., & Trzeciak, S. (2021). Validation of a 5-item tool to measure patient assessment of clinician compassion in hospitals. *Journal of General Internal Medicine*, 1–7. https://doi.org/10.1007/s11606-021-06733-5

Rodriguez-Homs, L., Hammill, B. G., Ryser, M. D., Phillips, H. R., & Mosca, P. J. (2020). Relationship between HCAHPS scores and survey response rate is linked to hospital size. *Journal of Patient Experience*, *7*(6), 1543–1548. https://doi.org/10.1177/2374373520932458

Romero-Garcia, M., Delgado-Hito, P., de la Cueva-Ariza, L., Martinez-Momblan, M. A., LluchCanut, M. T., Trujols-Albet, J., Juave-Udina, M. E., & Benito, L. (2019). Level of satisfaction of critical care patients regarding the nursing care received: Correlation with sociodemographic and clinical variables. *Australian Critical Care*, *32*(6), 486–493. https://doi.org/10.1016/j.aucc.2018.11.002

Roslan, S. B., & Lim, M. L. (2017). Nurses' perceptions of bedside clinical hand-off in a medical-surgical unit: An interpretive descriptive study. *Proceedings of Singapore Healthcare*, *26*(3), 150–157. https://doi.org/10.1177%2F2010105816678423

Rush, S. K. (2012). Bedside reporting: Dynamic dialogue. *Nursing Management*, *43*(1), 40–44. https://pubmed.ncbi.nlm.nih.gov/22217696/

Scheidenhelm, S., & Reitz, O. E. (2017). Hardwiring bedside shift report. *Journal of Nursing Administration*, *47*(3), 147–153. https://doi.org/10.1097/nna.0000000000000457

Shirey, M. R. (2013). Lewin's theory of planned change as a strategic resource. *Journal of Nursing Administration*, *43*(2), 69–72. https://doi.org/10.1097/nna.0b013e31827f20a9

Small, D. C., & Fitzpatrick, J. J. (2017). Nurse perceptions of traditional and bedside shift report. *Nursing Management, 48*(2), 44–49. https://journals.lww.com/nursingmanagement/Fulltext/2017/02000/Nurse_perceptions_of_traditional_and_bedside_shift.11.aspx

Sobel, J., Bates, J., Ng, V., Berkman, M., Nuno, T., Denningoff, K., & Stoneking, L. (2019). Effects of real-time surveys on patient satisfaction scores in the emergency department. *Education Research International, 2019*, 1–5. https://doi.org/10.1155/2019/6132698

Stimpfel, A. W., Fatehi, F., & Kovner, C. (2020). Nurses' sleep, work hours, and patient care quality, and safety. *Sleep Health, 6*(3), 314–320. https://doi.org/10.1016/j.sleh.2019.11.001

Summers, J. K., Humphrey, S. E., & Ferris, G. R. (2012). Team member change, flux in coordination, and performance: Effects of strategic core roles, information transfer, and cognitive ability. *Academy of Management Journal, 55*(2), 314–338. https://psycnet.apa.org/record/2012-13988-004

Tacchini-Jacquier, N., de Waele, E., Urben, P., Turini, P., & Verloo, H. (2020). Developing an evidence-based nursing handover standard for a multi-site public hospital in Switzerland: Protocol for a web-based, modified Delphi study. *Journal of Medical Internet Research Protocols, 9*(1), 1–11. https://www.researchprotocols.org/2020/1/e15910/PDF

Tan, A. K., Jr. (2015). Emphasizing caring components in nurse-patient-nurse bedside reporting. *International Journal of Caring Sciences*, *8*(1), 188–193. https://www.internationaljournalofcaringsciences.org/docs/21-Review-Amil-11.pdf

Tobiano, G., Bucknall, T., Sladdin, I., Whitty, J. A., & Chaboyer, W. (2018). Patient participation in nursing bedside hand-off: A systematic mixed methods review.

International Journal of Nursing Studies, *77*, 243–258. https://doi.org/https://doi.org/10.1016/j.ijnurstu.2017.10.014

Tran, T. T., & Gandolfi, F. (2020). Implementing Lewin's change theory for institutional improvements: A Vietnamese case study. *Journal of Management Research*, *20*(4), 199–210. https://indianjournals.com/ijor.aspx?target=ijor:jmr&volume=20&issue=4&article=001

Vines, M. M., Dupler, A. E., Van Son, C. R., & Guido, G. W. (2014). Improving client and nurse satisfaction through the utilization of bedside report. *Journal for Nurses in Professional Development, 30*(4), 66–173. https://pubmed.ncbi.nlm.nih.gov/25036080/

Wakefield, D. S., Ragan, R., Brandt, J., & Tregnago, M. (2012). Making the transition to nursing bedside shift reports. *Joint Commission Journal on Quality and Patient Safety*, *38*(6), 243–254. http://store.jointcommissioninternational.org/assets/1/14/S1-JQPS-0612_wakefield.pdf

Wang, T., & Gibbs, D. (2019). A framework for performance comparison among major electronic health record systems. *Perspectives in Health Information Management*, *16,* 1–12. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6931047/

Wardah, S. U., & Wardani, E. (2020). An evaluation of patient satisfaction with nursing care: A qualitative study in an Indonesian hospital. *Ethiopian Journal of Health Sciences*, *30*(6), 1011–1016. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8047235/

Watson, E. (2014). Nursing malpractice: Costs, trends, and issues. *Journal of Legal Nurse Consulting*, *25*(1), 26–31. http://www.aalnc.org/page/journal-v2.0

Watts, D. D., Slivinski, A., Garland, J. M., Kerley, D. R., Wilson, N. Y., Cooper, T., Howard, K., Dunne, J., Lieser, M. J., Berg, G. M., Wyse, R. J., Carrick, M. M., & Fakhry, S. M. (2021). The impact of nursing on trauma patient satisfaction: An analysis of HCAHPS from 112,283 patients. *Journal of Trauma Nursing*, *28*(4), 219–227. https://pubmed.ncbi.nlm.nih.gov/34210939/

Williams, C. L. (2018). A comparison of the risks and benefits of nursing bedside shift reports vs. traditional shift reports: A systematic review of the literature. *International Journal of Studies in Nursing*, *3*(2), 40–58. http://journal.julypress.com/index.php/ijsn/article/view/382/295

Wojciechowski, E., Pearsall, T., Murphy, P., & French, E. (2016). A case review: Integrating Lewin's theory with lean's system approach for change. *Online Journal of Issues in Nursing*, *21*(2), 1–13. https://doi.org/10.3912/OJIN.Vol21No02Man04

Appendix A: SWOT Analysis

This appendix consists of strengths, weaknesses, opportunities, and threats (SWOT) analysis. The analysis was performed to determine the opportunities and barriers for correction. The strengths are the nurses' receptiveness to change and contemporary practices, and they are convivial about project implementation.

Strengths	**Weaknesses**
Exceptionally skilled staff Excellent teamwork Nurses are receptive to change Commitment to provide safe, quality care	Multiple interruptions The nurse is doing other things during the report
Opportunities	**Threats**
Patients engaged in their care and can ask questions Leadership support–unit director, NM, head nurse, and charge nurses Educate patients and their families about the BSR upon admission Change of shift admissions Family members at the bedside	Educational meetings Patient interruptions Change of shift admissions Family members at the bedside

Appendix B: HCAHPS Survey Communication With Nurse Dimension

The HCAHPS scores will be examined by computing mean score totals for the three specific questions related to communication with the nurse, comparing data preimplementation and postimplementation of the BSR.

YOUR CARE FROM NURSES

1). During this hospital stay, how often did nurses treat you with courtesy and respect?

1–Never
2–Sometimes
3–Usually
4–Always

2). During this hospital stay, how often did nurses listen carefully to you?

1–Never
2–Sometimes
3–Usually
4–Always

3). During this hospital stay, how often did nurses explain things in a way you could understand?

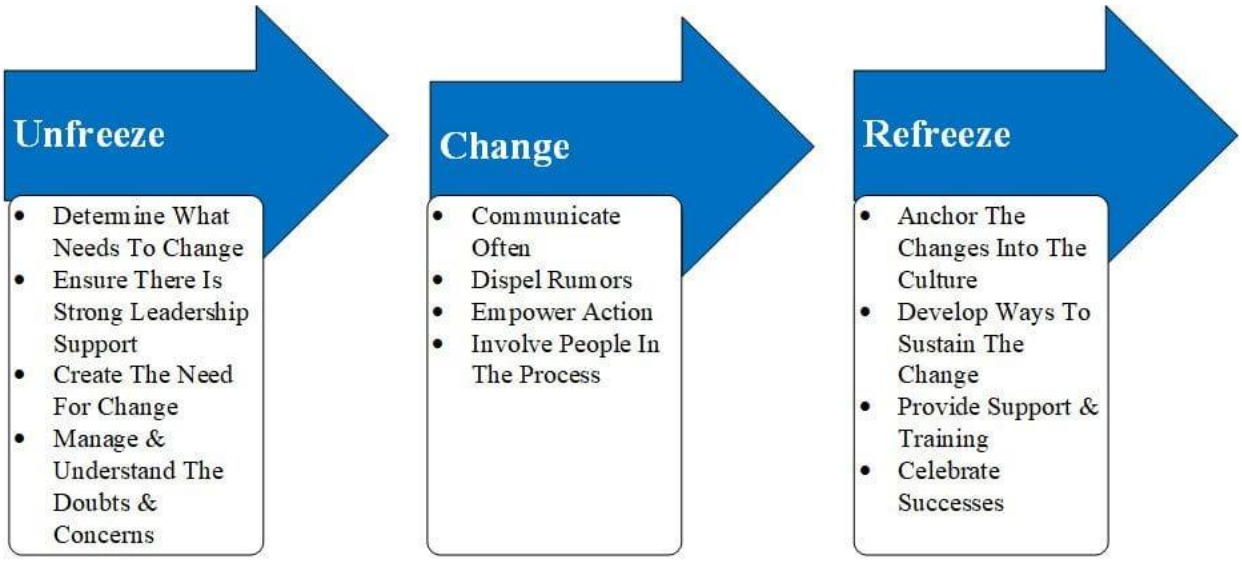
1–Never
2–Sometimes
3–Usually
4–Always

4). During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

1–Never
2–Sometimes
3–Usually
4–Always

Appendix C: Theoretical Framework: Lewin's Change Management Model

The NM must guide and maintain improvement changes at the bedside. Lewin's change management model is easy to understand and a simple framework to manage change. Nurse managers' and executives' formal training supports frequent use of Lewin's three-step change model.



Note. From *Lewin's Change Model*, by 9M, 2018, December 19, (https://9mconsulting.com/newsletter/lewins-change-model/).Copyright 2018 by 9M.

Appendix D: Patient BSR Brochure

The unit is now offering a new nurse-patient communication process: the bedside shift reports. A bedside shift report is a process where an off-going nurse gives a shift report to the incoming nurse on the patient they took care of. The BSR will take place at the patient's bedside. During the process, both nurses engage the patient in the process. During the bedside shift process, the patient is informed about medications, diagnostic tests, and the overall care plan while in the hospital. This process improves communication between patients and their nurses by allowing the patient to ask questions and comment on their care. The BSR will improve the ability to communicate important medical information to the patients. Verbal reports occur outside the room if the patient is sleeping and do not request to be awakened. The BSR will benefit the patient and allow verbal reports outside the room if they are asleep and did not request to be awakened. The BSR will benefit the patient and allow the nurses to continue delivering high-quality patient care that a patient expects and deserves while in the cardiac unit.

Appendix E: Nurse-Patient Worksheet

Registered nurses will use the nurse-patient worksheet to give and receive a report from the incoming and outgoing nurses. The nurse-patient worksheet will standardize the BSR.

Room_____Name_____

Admission Date _____Age_____M/F _____DOB ____Allergies_____

VS–T P R B/P Pain____ _____ _____ _____

Diagnosis_____

PMH _____

Code Status_____

Telemetry _____

Service/Provider_____

Consults_____

Diet_____

Blood sugar check_____

Supplemental 02_____

IV_____

IV Fluids_____

Tubes/Drains_____

GI/GU_____

Skin/Wounds_____

ADD_____

Notes_____

Appendix F: BSR Audit Tool

The BSR is a simple audit tool to guide nurse educators' observations. The audit scores are shared with the NMs and RNs, providing data on which parts of the BSR the nurses are performing and which they are omitting.

The BSR Audit Tool	**Number of Nurses/Shifts**	**Time**	**Report Shift/Date/Time**
Number of Nurses/Shift			
Report Start Time			
Report End Time			
Total Time			
Auditor			

Appendix G: IRB Approval Letter

November 11, 2021

Kasandra Johnson

Department of Graduate and Professional Studies Abilene Christian University

Dear Kasandra,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled "The Bedside Shift Report and Patient Satisfaction," (IRB# 21-142) is exempt from review under Federal Policy for the Protection of Human Subjects.

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

Megan Roth, Ph.D.

Director of Research and Sponsored Program

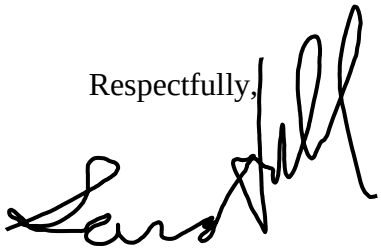
Appendix H: Permission Letter

November 8, 2021

Director of Doctor of Nursing Practice,

On behalf of XXXXX, and as the manager of the cardiac unit, we are pleased to give formal written consent for Kasandra Johnson, a student at your university, to perform her project, The Bedside Shift Report and Patient Satisfaction at this facility. In addition, she may use HCAHPS results in the nurse domain from April 2020 and April 2021. The study data is protected by HIPPA. This data has been de-identified from this source in accordance with the HIPPA privacy rule.

Respectfully,



XXXXX

Clinical Nurse Manager Cardiac Services

Appendix I: BSR Policy

The policy presents guidelines for consistency in performing the BSR to safeguard and sustain high scores in the HCAHPS in nurse-patient communication, delivering quality care, and standardized shift reports.

- Staff involved: RNs who perform patient care at the bedside
- Guidelines
- Explain the BSR upon admission and provide a copy of the BSR brochure
- Complete the BSR worksheet
- Introduce the patient to the incoming RN
- Empower the patient by encouraging the patient to engage the BSR
- Sensitive data addressed by the doctor with the patient, such as a new diagnosis, will be discussed outside the patient's room
- Nurse shift-to-shift reports include but are not restricted to the patient's reason for present admission, diagnosis, patient's history, code status, allergies, diet, pain status, drains, lines, dressings, wounds, and plan of care
- All RNs must perform end of shift communication at the patient's bedside with the patient