JNPD Journal for Nurses in Professional Development • Volume 30, Number 4, 166–173 • Copyright © 2014 Wolters Kluwer Health | Lippincott Williams & Wilkins

Improving Client and Nurse Satisfaction Through the Utilization of Bedside Report

CE
2.8 ANCC Contact Hours

Mary M. Vines, MN, RN, CMSRN, CHES ❍ Alice E. Dupler, JD, APRN-BC ❍
Catherine R. Van Son, PhD, RN ❍ Ginny W. Guido, JD, MSN, RN, FAAN

Bedside reporting improves client safety and trust and facilitates nursing teamwork and accountability; however, many nurses do not consider it best practice when caring for their clients. A literature review was conducted to determine whether bedside report is an essential shift handover process that promotes both client and nursing satisfaction. Implications for nurses in professional development are discussed, and strategies for developing and implementing bedside report using Lewin's theory of planned change are provided.

Effective communication is essential to maintain a safe and trusting environment for clients. Eighty percent of medical errors are attributed to miscommunication among caregivers (American Nurses Association, 2012). Miscommunication is also a leading contributor of patient harm, identified in more than 80% of medical malpractice lawsuits (Lang, 2012). Thus, increased emphasis has been placed on effective communication strategies that promote client safety and facilitate nursing teamwork.

The purpose of this article is to evaluate one such strategy, bedside report, to determine whether evidence supports its use as an essential shift handover practice that promotes safety and facilitates client and nurse satisfaction within an adult clinical care environment. Implications for nurses in professional development are discussed, and strategies for developing and implementing bedside report using Lewin's theory of planned change are provided.

Mary M. Vines, MN, RN, CMSRN, CHES, is an Adjunct Nursing Instructor at Columbia Basin College, Richland, Washington, and a Surgical Staff Nurse at Kadlec Regional Medical Center, Richland, Washington.

Alice E. Dupler, JD, APRN-BC, is an Associate Professor at the School of Nursing and Human Physiology, Gonzaga University and a Clinical Associate Professor at College of Nursing, Washington State University, Spokane.

Catherine R. Van Son, PhD, RN, is an Assistant Professor at College of Nursing, Washington State University, Spokane.

Ginny W. Guido, JD, MSN, RN, FAAN, is the Regional Director of Nursing and Assistant Dean at College of Nursing, Washington State University, Vancouver.

The authors have disclosed that they have no significant relationship with, or financial interest in, any commercial companies pertaining to this article.

ADDRESS FOR CORRESPONDENCE: Mary Vines, MN, RN, CMSRN, CHES, College of Nursing, Washington State University, P.O. Box 1495, Spokane, WA 99210 (e-mail: mvines12@hotmail.com).

DOI: 10.1097/NND.0000000000000057

BACKGROUND

Communication errors can be verbal or written and involve all members of the healthcare team. It can be a failure to relay critical laboratory results or medication information to another caregiver, resulting in preventable complications (Agency for Healthcare Research and Quality, 2003). Although it can occur at any time during client care, the greatest risk for miscommunication is during shift handover (Sand-Jecklin & Sherman, 2013).

The standardization of shift handovers was identified as one of the 2009 National Client Safety Goals from The Joint Commission (TJC). Shift handovers must include up-to-date information about the care, treatment, current condition, and recent or anticipated changes in the client. It should also encourage client involvement in their care (TJC, 2008). Employing a standardized bedside report as a universal handover process is one strategy that in part meets the requirements of these goals.

Anderson and Mangino (2006) identified specific motivating factors to support the need for bedside reporting. Today, clients are more informed consumers, accessing the Internet to gain knowledge about their conditions and treatment options. Educated clients desire a collaborative model of care to be involved in their plan of care and to be kept informed of their condition and treatment options. Although the intent of bedside report is to provide the oncoming nurse with pertinent up-to-date information on the client's clinical course and plan of care, it also allows an opportunity for clients and family members to contribute their input and desires, opening the lines of communication (Griffin, 2010; Tobiano, Chaboyer, & McMurray, 2013).

Bedside report increases client safety and satisfaction; creates trust between the nurse and client; reduces communication errors; and promotes accountability, teamwork, and respect among staff (Cairns, Dudjak, Hoffman, & Lorenz, 2013; Reinbeck & Fitzsimmons, 2013; Sand-Jecklin & Sherman, 2013). Nevertheless, Cairns et al. (2013) indicated that shift reports are occurring away from the client's bedside, with increased length of time, disorganization of

content, and interruptions. Verbal report alone, without the client's collaboration, can impact safety if information is incomplete or communicated poorly because of interruptions or distractions (Anderson & Mangino, 2006; Cairns et al., 2013).

Regardless of the evidence, nurses are hesitant to adopt bedside report as a standard of care for client handover (Caruso, 2007; Sand-Jecklin & Sherman, 2013; Wakefield, Ragan, Brandt, & Tregnago, 2013). One obstacle results from the responsibility to protect client confidentiality, which is at risk when patients are sharing semiprivate rooms (Sand-Jecklin & Sherman, 2013; Wakefield, et al., 2012). Medical information can be unintentionally disclosed during bedside report, and staff may be concerned that this is a violation of the Health Insurance Portability and Accountability Act (HIPAA). However, the HIPAA Privacy Rule "permits certain incidental uses and disclosures of protected health information to occur when the covered entity has in place reasonable safeguards and minimum necessary policies and procedures to protect an individual's privacy" (Office for Civil Rights, 2002, para. 1). Therefore, the apprehension to provide bedside reporting related to protecting client confidentiality can be overstated, given that it is already incorporated within the HIPAA Privacy Rule.

THEORETICAL FRAMEWORKS

Hildegard Peplau's theory of interpersonal relations and Kurt Lewin's theory of planned change are two theoretical frameworks that are applicable to the bedside report process.

Peplau focused on the interactions between the nurse and the client in an attempt to establish a therapeutic and trusting relationship. Bedside report is an essential component to building this relationship, and Peplau's theory provides the conceptual framework to help guide caregivers to succeed (Radtke, 2013). Peplau identified three phases within the theory of interpersonal relations: orientation, working, and termination. Clients are the main focus of the first phase, orientation. During bedside report, the nurse introduces himself or herself, explains the process of bedside report, obtains the client's permission, and then proceeds. During the second phase, "working," caregivers and clients collaborate to identify needs and determine methods to accomplish them, developing and initiating a plan of care. During the third phase, "termination," when the needs of the client are met, the relationship comes to an end (McCarthy & Aquino-Russell, 2009).

Lewin's theory of planned change can be used as a foundation to facilitate and implement education for staff about the use of bedside report as a fundamental handover practice (Caruso, 2007; Chaboyer, McMurray, & Wallis, 2009; Costello, 2010; Hagman, Oman, Kleiner, Johnson, & Nordhagen, 2013; McMurray, Chaboyer, Wallis, & Fetherston, 2010). There are three stages to the change theory: unfreezing, moving, and refreezing. These stages outline the activities related to educating and informing to change perspective, inspiring and directing new activities, and codifying and establishing a new set of norms postadoption. During the unfreezing phase, the proposed change of bedside report, the reasoning behind it, and the anticipated outcomes are presented and explained to the staff. A force field analysis should also be conducted to determine motivating and restraining forces, which may assist or impede the change. By addressing and overcoming the restraining forces, motivating forces increase and enable the individual to progress into the second stage, which is moving (Costello, 2010). It is during the moving stage that the process of initiating and conducting bedside report begins. Lastly, the final stage, refreezing, is accomplished when bedside report is considered the exclusive handover process, utilized at every shift change (Kassean & Jagoo, 2005).

LITERATURE REVIEW

Methods

A review of literature served as a foundation to establish whether or not bedside report is an essential handover practice to facilitate client and nurse satisfaction. Using keywords *client satisfaction*, *nursing satisfaction*, *bedside report*, *bedside handoff*, *shift report*, and *shift handoff*, a literature search was conducted in Academic Search Complete, ArticleFirst, CINAHL, the Cochrane Library, MEDLINE, PubMed, and WorldCat databases. Ninety-five publications were retrieved; the results were then limited by date (2006 to present), setting (hospital/adult clinical care), population (adult), and relevance to purpose statement. Subsequently, nine articles were chosen for this review and were categorized into two sections: client satisfaction and nursing satisfaction (see Figure 1). These categories provided the organizational framework for this article and were examined in detail.

Findings

Client satisfaction

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a 27-item survey, which measures client perceptions of their hospital experience (Centers for Medicare & Medicaid Services, 2014). One focus of the HCAHPS survey is nursing communication. Clients are asked how often nurses listened carefully to them, whether nurses explain things in a way they could understand, and if nurses treat them with courtesy and respect. Respondents answer these questions on a 4-point rating scale of *never*, *sometimes*, *usually*, and *always*. Higher scores signify higher satisfaction with communication (Centers for Medicare & Medicaid Services, 2013).

Lack of communication between nurses and clients has been verified through the HCAHPS surveys. Often, clients feel excluded from information and decisions related to

Literature Review

Client Satisfaction

Author	Hierarchy of Evidence	Findings
Anderson and Mangino (2006)	Level III- CT without a control group	HCAHPS scores increased in three communication areas related to nursing care
Cairns and Dudjak (2013)	Level III- CT without a control group	Reported satisfaction with inclusion in their plan of care through bedside handoff
Frietag and Carroll (2011)	Level III- CT without a control group	Using SBAR with report increased the clients perceptions of being informed by 5.5%
Maxson, Derby, Wrobleski, and Foss (2012)	Level III- CT without a control group	Clients report feeling safer, and appreciated knowing their plans of care and meeting the new nurse
McMurray, Chaboyer, Wallis, Johnson, and Gehrke (2011)	Level VI: Descriptive study	Providing report in front of the client increased the client's feelings of being involved and being recognized as a person first
Reinbeck and Fitzsimmons (2013)	Level III- CT without a control group	Using SBAR with report increased HCAHPS scores in communication by 8%
Sand-Jecklin and Sherman (2012)	Level III- CT without a control group (Mixed methods - quantitative and qualitative data)	Post implementation revealed significantly higher scores; Limited sample size was noted
Wakefield, Ragan, Brandt, and Tregnago (2012)	Level III- CT without a control group	Scores increased an average of 11.1 points; Limited sample size was noted

Nursing Satisfaction

Author	Hierarchy of Evidence	Findings
Anderson and Mangino (2006)	Level III- CT without a control group	Enhances accountability, prioritization, visualization, and staff relationships; Opportunity for experiential learning
Cairns and Dudjak (2013)	Level III- CT without a control group	Increased scores in satisfaction and perceptions; More staff accountability and sense of confidence
Chaboyer, McMurray, and Wallis (2010)	Level VI: Descriptive study	Improved accuracy, accountability, delivery, preparation, and communication, and client centered care
Evans, Grunawalt, McClish, Wood, and Friese (2012)	Level III- CT without a control group	Increased from 37% to 78%; Positives included assessing the client immediately, and clarifying or asking questions with the outgoing staff
Jeffs, Acott, Simpson, Campbell, Irwin, Lo, … Cardoso (2013)	Level VI: Qualitative study	Results demonstrated two themes- ability to clarify information and intercept errors and visualize clients and prioritize care
Maxson, Derby, Wrobleski, and Foss (2012)	Level III- CT without a control group	Statistically significant benefits of increased communication, accountability, and prioritization
Reinbeck and Fitzsimmons (2013)	Level III- CT without a control group	Provides immediate client contact and visualization, and a sense of teamwork and respect among staff
Sand-Jecklin and Sherman (2012)	Level III- CT without a control group	Improves accountability and increases client involvement, and is an effective and efficient mode of staff communication

FIGURE 1 Literature review.

their health and hospitalization (Radtke, 2013). Bedside report can contribute to an increase in satisfaction and HCAHPS communication scores, as it assists in keeping clients informed and involved in their plan of care (Cairns et al., 2013; Maxson, Derby, Wrobleski, & Foss, 2012; McMurray, Chaboyer, Wallis, Johnson, & Gehrke, 2011; Radtke, 2013). It also allows clients to address problems or concerns and correct inaccuracies (Maxson et al., 2012).

The traditional taped or verbal report can result in a communication failure among staff members, increasing errors and decreasing client safety. These factors were cited by Anderson and Mangino (2006) as driving forces behind the implementation of bedside report on a 32-bed surgical unit utilizing a client-centered care delivery model. In preparation for implementation, the staff received classroom education, with written handouts. Upon admission to the unit, clients received information regarding the expectations of bedside report. Eight months after initiation, results obtained from informal rounds conducted by unit managers, as well as HCAHPS scores, were analyzed and compared to the preimplementation data. Results showed that bedside report increased in client satisfaction within three key areas of communication: (1) "nurses kept me informed" (56%–99%), (2) "staff worked well together to provide care" (98%–99%), and (3) "staff included me in decisions regarding my treatment" (58%–97%; Anderson & Mangino, 2006).

Freitag and Carroll (2011) described an analysis of shift handoffs conducted on a 24-bed telemetry unit. After examining the current process, it was determined that the best method for improving and facilitating client communication and participation was to relocate nurse-to-nurse handoff to the bedside. Over a 3-month period, a pilot study was conducted on the unit, employing both bedside report and the Situation, Background, Assessment, Recommendation (SBAR) handoff tool. Using Press–Ganey client satisfaction scores to measure outcomes, initiation of bedside report contributed to a 4.4% increase in overall client satisfaction and a 5.5% increase in client perceptions of being informed (2011).

Reinbeck and Fitzsimmons (2013) observed similar results when a 592-bed acute care hospital initiated bedside report to enhance client safety and experiences through communication. To make the report concise, the staff chose to utilize the SBAR handoff tool. Within 6 months of implementation, HCAHPS scores within nursing communication increased from 74 to 80, an 8% change as compared to baseline, confirming the positive influence that bedside report has on client satisfaction (Reinbeck & Fitzsimmons, 2013).

Sand-Jecklin and Sherman (2013) discussed the introduction of bedside report on a medical surgical unit in a large teaching hospital. Using Cronbach's alpha to determine and establish reliability, the "Client Views on Nursing Care" survey (Sand-Jecklin & Sherman, 2013) was selected to gather data. The survey contained 17 questions characteristic of nursing care, including respect, listening, communication, and teaching. Data were collected from 232 clients and 70 family members before initiation and from 178 clients and 72 family members 3 months after implementation. Utilizing independent *t* tests, the research team determined that bedside report significantly impacted responses; clients and family members reported that nurses made sure they knew who their nurse was ($p = .029$) and included them in shift report discussions ($p = .017$) (Sand-Jecklin & Sherman, 2013, p. 4).

A 20-bed health center in the Midwest transitioned to bedside report with the intention of improving client satisfaction (Wakefield et al., 2012). Before the changeover, an analysis was conducted on the existing report process, collecting baseline data through nurse surveys and client communication scores. For 6 months after implementation, monthly client satisfaction scores, obtained through the Press–Ganey survey instrument, increased by an average of 11.1 points (range, 8.7–14.0), as compared to preimplementation. Longitudinal results, which were observed 23 months after initiation, showed an increase of 6.9 points (range, 5.5–7.6). In addition, during this time, 43 client interviews were conducted in an attempt to determine the client's perceptions of bedside report and how satisfied they were with the process. Seventy-two percent of surveyed clients indicated that they were very satisfied with bedside report.

Nursing satisfaction

Researchers have identified positive nursing perceptions toward bedside report. Nurses utilizing bedside report stated that it reduced communication errors among staff; promoted accountability; and enhanced teamwork, collaboration, and respect (Anderson & Mangino, 2006; Cairns et al., 2013; Reinbeck & Fitzsimmons, 2013; Sand-Jecklin & Sherman, 2013). Bedside report allows for immediate visualization of the client during shift change, facilitating the prioritization of care (Anderson & Mangino, 2006; Jeffs et al., 2013; Maxson et al., 2012). In addition, it encourages experiential learning and improves the accuracy and efficacy of shift report (Anderson & Mangino, 2006; Sand-Jecklin & Sherman, 2013).

Nurses at a large academic hospital expressed concerns over disorganization, length, and accuracy of shift reporting. As a result, the hospital launched bedside reporting on a 23-bed trauma unit to improve efficiency and value of the handover process (Cairns et al., 2013). Anonymous surveys were completed by staff 3 months prior to and following the implementation of bedside reporting. The survey tool was developed by an investigator, tested on nursing management to determine clarity, and then uploaded to Survey Monkey. Using a 5-point Likert scale (1 = *strongly agree* to 5 = *strongly disagree*), nurses were asked to rank the current automated method based on conciseness of the report, accuracy of information, nurse availability after report, and excessive time spent on report. Three months following the initiation of bedside report, nursing satisfaction increased in several areas; positive change was identified in conciseness of the report (38% [$n = 29$] to 77.8% [$n = 18$]), accuracy of information (72.4% [$n = 29$] to 83.4% [$n = 18$]), and nurse availability after report (75.9% [$n = 29$] to 88.9% [$n = 18$]).

Nurses reported that time spent on report decreased from 48.2% (n = 29) to 38.9% (n = 18). In addition, the nurses believed that bedside report generated more staff accountability and provided a greater sense of confidence in themselves while providing client care (Cairns et al., 2013).

Chaboyer et al. (2010) conducted a descriptive study in six medical and surgical units in two hospitals that focused on the components and processes of bedside report in relation to nurse perceptions and outcomes. The components of bedside report consisted of the oncoming team, as well as the outgoing team leader, the client, a handover sheet, which included the client's demographics, diagnosis, history, and clinical condition, and the bedside chart containing medication records and risk assessment charts. The processes were identified as three phases: before, during, and after handover. Before handover, involved staff updating the computer generated handover sheet and informing the client about the upcoming shift change. During handover, information was reviewed and communicated at the bedside, allowing for client contributions. Perceived outcomes of bedside handover and its components and processes were identified through interviews with 34 nurses. Nurses acknowledged that bedside report improved accuracy, accountability, delivery, preparation, and communication, and it encouraged client-centered care (Chaboyer et al., 2010).

The initiation of bedside report on a 32-bed medical–surgical unit was the result of nurse dissatisfaction (Evans, Grunawalt, McClish, Wood, & Friese, 2012). Literature on best practices for handover was reviewed by the unit manager, nurse specialist, nurse supervisor, and clinical educator. It was determined that bedside report may resolve some of the issues with the current handover process, such as the lack of client involvement. Preimplementation data were collected to establish a baseline, and postimplementation data were collected 6 months after to evaluate effectiveness. After transferring handover to the bedside, nurse satisfaction scores increased from a baseline of 37% to 78%. Having the ability to assess the client immediately while conducting a report and then clarify or ask questions with the outgoing shift contributed to this increase in satisfaction (Evans et al., 2012).

Maxson et al. (2012) conducted research in a small 11-bed acute care unit to determine whether bedside report increased communication, accountability, and prioritization among nursing staff and, therefore, increased nursing satisfaction. Using a survey developed by an investigator with a 5-point Likert scale (1 = *strongly agree* to 5 = *strongly disagree*), 15 nurses participated in a pre- and post- bedside report survey focused on the connection between handover and the hypothesized benefits. Baseline scores had been between 2 (*agree*) and 4 (*disagree*). Every question on the post-bedside report survey scored a 1, indicating the nurses strongly agreed that bedside report increased accountability, communication, and prioritization. In addition, nurses stated they felt more prepared to speak to physicians about their clients after utilizing bedside report (Maxson et al., 2012).

IMPLICATIONS FOR THE NURSES IN PROFESSIONAL DEVELOPMENT

The reviewed studies provide evidence that supports using bedside report as an essential shift handover practice within an adult clinical care environment, with improvements in client and nurse satisfaction determined repeatedly. It is integral to the development of best practices that this current evidence is included. Bedside reports, modified to meet client preferences and values when exercising clinical judgment, facilitates patient-centered care.

Lewin's theory of planned change was cited in the reviewed literature as the foundation for transforming nurse attitudes and shift handovers to the bedside (Caruso, 2007; Chaboyer et al., 2009; Costello, 2010; Hagman et al., 2013; McMurray et al., 2010). Implications and suggestions for developing and initiating an educational inservice for staff on bedside report utilizing Lewin's theory as well as recommendations for maintaining the new handover process are described below.

Implementing Bedside Report Using Lewin's Theory of Planned Change

Lewin's theory of planned change can provide the foundational framework to achieve success when implementing bedside report (see Figure 2).

Unfreezing phase. The purpose of the unfreezing phase is to confront and challenge existing staff attitudes and beliefs toward bedside report. Despite research and documentation of the benefits of bedside reporting, numerous barriers are cited in the opposition against implementing it into standard practice. Although the barriers related to nurses comfort level can vary in origin and validity, it is understood that nurses are generally supportive of change if it improves client care and outcomes (McMurray et al., 2010). Appealing to this favorability is critical in "unfreezing" the challenge to change.

Using valid and reliable evidence retrieved from literature and TJC recommendations for best practice, a committee composed of staff nurses, unit managers, and clinical educators who support bedside report can lead the change process, providing information to the staff behind the need for change to bedside handover. Informational meetings with open forums can allow staff to ask questions, receive answers, and express concerns about the impending change in a nonjudgmental environment (Burke & McLaughlin, 2012; Caruso, 2007; Grant & Colello, 2009).

Moving phase. In the moving phase, the process of bedside report is introduced, with a focus on achieving staff acceptance. To begin, the committee should explore current

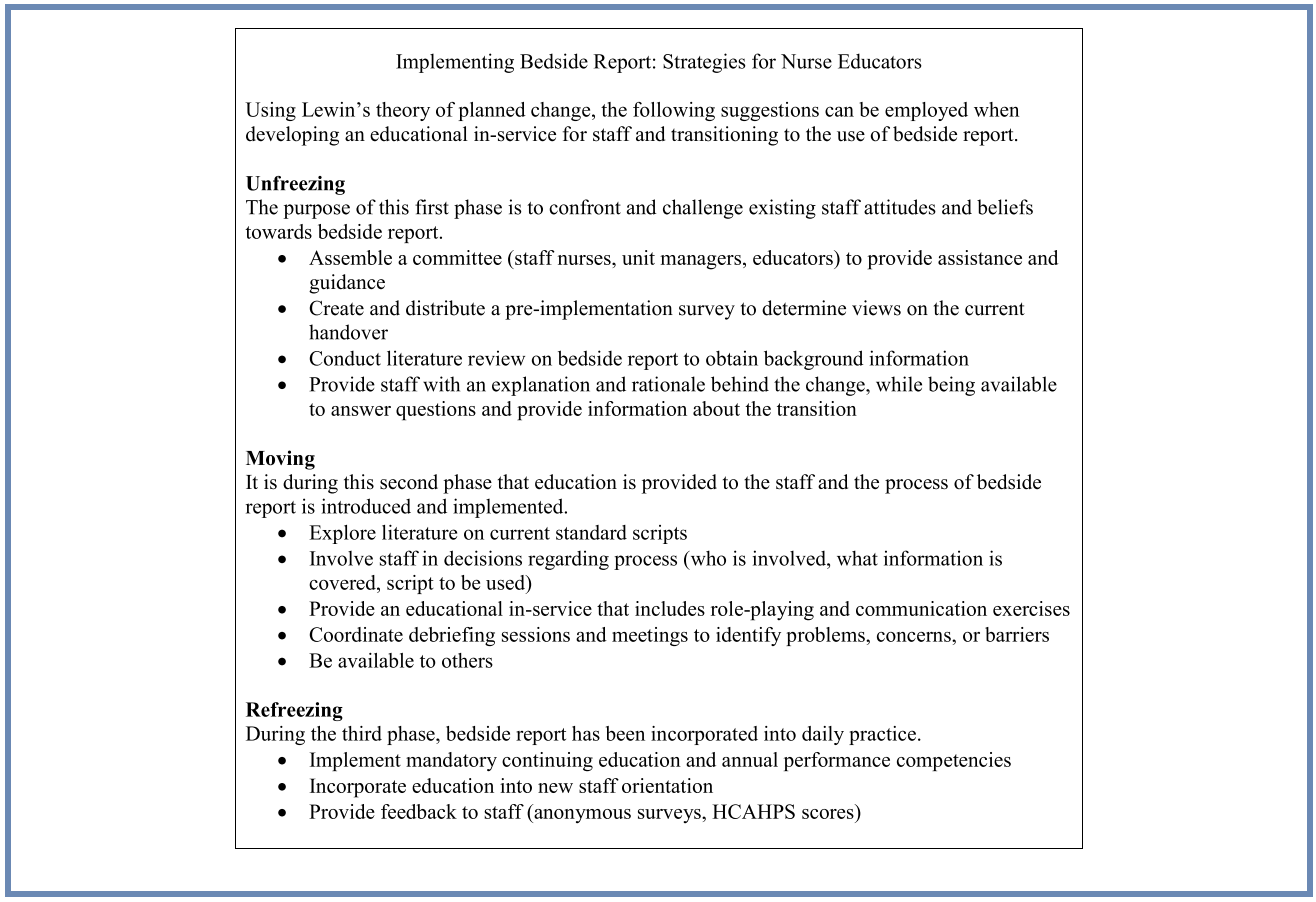

FIGURE 2 Implementing bedside report: Strategies for nurse educators.

literature on standard scripts used during bedside report. Existing handover scripts such as SBAR, AIDET (acknowledge, introduce, duration, explanation, and thank you), and ISHAPED (introduction, story, history, assessment, plan, error prevention, and dialogue) have been widely accepted and useful for communicating essential elements during handover (Friesen, Herbst, Turner, Speroni, & Robinson, 2013; McMurray et al., 2010; Reinbeck & Fitzsimmons, 2013; Sand-Jecklin & Sherman, 2013). Ultimately, however, the final script selection should be made by the affected staff (Costello, 2010; Risenberg, Leitzch, & Cunningham, 2010).

Staff should participate in determining the actual process of the bedside report. Chaboyer et al. (2009) outlined that important components of the process should include who will be involved in the handoff (oncoming and off-going nurse, nursing assistant, lead nurse) and what information should be covered (vital signs, flow sheet, medications, plan of care). Safety checks, including addressing client-controlled analgesics (PCA) and intravenous fluids, should be included (Costello, 2010), as well as a nonmedication review, including a room check, quick access to oxygen, tubing, suction, and an Ambu bag.

Once the components and processes have been determined, an educational inservice should be conducted to present and discuss expectations, address concerns that were identified during the unfreezing phase, and reiterate the importance behind bedside report. Another aspect of the inservice is the enhancement of communication skills, which contributes to client satisfaction (McMurray et al., 2011). Role-playing can provide an opportunity to cultivate and improve communication skills, while easing anxiety and increasing confidence in the ability to perform bedside report (Burke & McLaughlin, 2013; Cairns et al., 2013; Caruso, 2007). Novice nurses may need guidance on what material should be communicated during report, whereas veteran nurses may need reminders on what is appropriate for the bedside versus what should be communicated elsewhere. Role-playing can be especially beneficial when handling difficult situations and clients (Hagman et al., 2013). Using nonmedical terminology during handover should also be emphasized, as it enables clients to comprehend their plan of care more thoroughly, providing them with the opportunity to share their opinions and expectations (McMurray et al., 2011).

Refreezing phase. In the refreezing phase, bedside report has been incorporated into daily practice and has become the primary handover method utilized at every shift change. Evaluations, anonymous surveys, debriefing

sessions, and monthly meetings can identify unresolved issues or concerns with the new process. Obtaining continuous staff feedback allows for modifications and generates greater nurse satisfaction and adherence (Anderson & Mangino, 2006; Caruso, 2007; Costello, 2010). Sharing (HCAHPS) scores with staff can also provide tangible evidence of client satisfaction, providing the encouragement needed to sustain the change (Baker, 2010). Mandatory continuing education and annual performance competencies for staff may be necessary to maintain the new practice. In addition, new staff orientation should include training on bedside report, so individuals are aware of the expectations for handover (Chaboyer et al., 2009; McMurray et al., 2010).

RECOMMENDATIONS FOR FUTURE RESEARCH

Although there are several handoff methods in use, bedside report certainly seems to warrant further study to continue to demonstrate the opportunities to improve client satisfaction, nursing satisfaction, and client outcomes.

Athwal, Fields, and Wagnell (2009) stated that "shift reports that lack a formal structure and guidelines can lead to inefficiencies and the sharing of irrelevant and inadequate information" (p. 143). The connection between the use of a standardized script or handoff tool during bedside report and its correlation to an increase in client and nurse satisfaction should be further examined. In addition, use of whiteboards in conjunction with bedside report can be further tested to assure that conveyed information is relevant, accurate, consistent, and easy for staff to use (Sehgal, Green, Vidyarthi, Blegen, & Wachte, 2010). Investigating a connection between whiteboard use during bedside report and client and nurse satisfaction should be further examined.

Further investigation into the role of bedside report and its connection to client outcomes is warranted. Current research suggests that initiating bedside reports is correlated with a decrease in client falls during shift change (Athwal et al., 2009; Frietag & Carroll, 2011) and a decrease in medication errors (Sand-Jecklin & Sherman, 2013). Others have also suggested that the relationship between bedside report and activation of rapid response or code teams should also be analyzed to examine its effect on adverse or sentinel events.

CONCLUSION

The greatest risk for miscommunication within the healthcare environment is during shift handover (Sand-Jecklin & Sherman, 2013). In an effort to eliminate this risk, TJC recognized the need to standardize shift handovers and involve the client during the interaction (Joint Commission on Accreditation of Healthcare Organizations, 2008). Employing bedside report as a universal handover process is one strategy that in part meets these provisions. The purpose of this article was to determine whether bedside report is an essential handover practice that facilitates both client and nursing satisfaction in care settings. Evidence showed a direct correlation between this handover and increased satisfaction in both groups, validating the importance of shifting the process to the bedside. The nurse in professional development can be the primary facilitator for change, making bedside report an effective communication tool for the shift change process.

References

Agency for Healthcare Research and Quality. (2003). *AHRQ's client safety initiative: Building foundations, reducing risk. Interim report to the Senate Committee on Appropriations* (AHRQ Publication No. 04-RG005). Rockville, MD.

American Nurses Association. (2012, October 5). *Tackling miscommunication among caregivers*. Retrieved from www.theamericannurse.org/index.php/2012/10/05/tackling-miscommunication-among-caregivers

Anderson, C., & Mangino, R. (2006). Nurse shift report: Who says you can't talk in front of the client? *Nursing Administration Quarterly, 30*(2), 112–122.

Athwal, P., Fields, W., & Wagnell, E. (2009). Standardization of change-of-shift report. *Journal of Nursing Care Quality, 24*(2), 143–147.

Baker, S. (2010). Bedside shift report improves patient safety and nurse accountability. *Journal of Emergency Nursing, 36*(4), 355–358.

Burke, W., & McLaughlin, D. (2012). (2013). Partnering for change. *American Journal of Nursing, 113*(2), 47–51.

Cairns, L., Dudjak, L., Hoffman, R., & Lorenz, H. (2013). Utilizing bedside shift report to improve the effectiveness of shift handoff. *Journal of Nursing Administration, 43*(3), 160–165.

Caruso, E. (2007). The evolution of nurse-to-nurse bedside report on a medical-surgical cardiology unit. *Medical Surgical Nursing, 16*(1), 17–22.

Centers for Medicare & Medicaid Services. (2013, August). *HCAHPS fact sheet*. Retrieved from www.hcahpsonline.org/Facts.aspx

Centers for Medicare & Medicaid Services. (2014, March). *Standard HCAHPS survey*. Retrieved from www.hcahpsonline.org/survey instrument.aspx

Chaboyer, W., McMurray, A., Johnson, J., Hardy, L., Wallis, M., & Chu, F. (2009). Bedside handover: Quality improvement strategy to "transform care at the bedside." *Journal of Nursing Care Quality, 24*(2), 136–142.

Chaboyer, W., McMurray, A., & Wallis, M. (2010). Bedside nursing handover: A case study. *International Journal of Nursing Practice, 16*, 27–34.

Costello, M. (2010). Changing handoffs: The shift is on. *Nursing Management, 41*(10), 39–42.

Evans, D., Grunawalt, J. McClish, D., Wood, W., & Friese, C. (2012). Bedside shift-to-shift nursing report: Implementation and outcomes. *MedSurg Nursing, 21*(5), 281–292.

Freitag, M., & Carroll, V. (2011). Handoff communication: Using failure modes and effects analysis to improve the transition in care process. *Quality Management in Health Care, 20*(2), 103–109. doi: 10.1097/QMH.0b013e3182136f58

Friesen, M., Herbst, A., Turner, J., Speroni, K., & Robinson, J. (2013). Developing a client-centered ISHAPED handoff with client/family and parent advisory councils. *Journal of Nursing Care Quality, 28*(3), 208–216.

Grant, B., & Colello, S. (2009). Engaging the client in handoff communication at the bedside. *Nursing, 39*(10), 22–24.

Griffin, T. (2010). Bringing change-of-shift report to the bedside: A client- and family-centered approach. *Journal of Perinatal and Neonatal Nursing, 24*(4), 348–353.

Hagman, J., Oman, K., Kleiner, C., Johnson, E., & Nordhagen, J. (2013). Lessons learned from the implementation of a bedside handoff model. *Journal of Nursing Administration, 43*(6), 315–317.

Jeffs, L., Acott, A., Simpson, E., Campbell, H., Irwin, T., Lo, J., … Cardoso, R. (2013). The value of bedside shift reporting: Enhancing nurse surveillance, accountability, and client safety. *Journal of Nursing Care Quality, 28*(3), 229–232.

Joint Commission on Accreditation of Healthcare Organizations. (2008). 2009 National Client Safety Goals. *Joint Commission Perspectives, 28*(7), 11–14.

Kassean, H., & Jagoo, Z. (2005). Managing change in the nursing handover from traditional to bedside handover—A case study from Mauritius. *BioMed Central Nursing, 4*(1), 1–6. doi:10.1186/1472-6955-4-1

Lang, E. (2012). A better client experience through better communication. *Journal of Radiology Nursing, 31*(4), 114–119. doi: 10.1016/j.jradnu.2012.08.001

Maxson, P., Derby, K., Wrobleski, D., & Foss, D. (2012). Bedside nurse-to-nurse handoff promotes client safety. *MEDSURG Nursing, 21*(3), 140–145.

McCarthy, C., & Aquino-Russell, C. (2009). A comparison of two nursing theories in practice: Peplau and Parse. *Nursing Science Quarterly, 22*(1), 34–40.

McMurray, A., Chaboyer, W., Wallis, M., & Fetherston, C. (2010). Implementing bedside handover: Strategies for change management. *Journal of Clinical Nursing, 19*, 2580–2589.

McMurray, A., Chaboyer, W., Wallis, M., Johnson, J., & Gehrke, T. (2011). Clients' perspectives of bedside nursing handover. *Collegian, 18*(1), 19–26.

Office for Civil Rights. (2002). *HIPAA Privacy: Incidental uses and disclosures* [45 CFR 164.502(a)(1)(iii)]. U.S. Department of Health and Human Services. Retrieved from www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/incidentalusesanddisclosures.htm

Radtke, K. (2013). Improving client satisfaction with nursing communication using bedside shift report. *Journal for Advanced Nursing Practice, 27*(1), 19–25.

Reinbeck, D., & Fitzsimons, V. (2013). Improving the client experience through bedside shift report. *Nursing Management, 44*(2), 16–17.

Risenberg, L., Leitzch, J., & Cunningham, J. (2010). Nursing handoffs: A systemic review of literature. *American Journal of Nursing, 110*(4), 24–34.

Sand-Jecklin, K., & Sherman, J. (2013). Incorporating bedside report into nursing handoff: Evaluation of change in practice. *Journal of Nursing Care Quality, 28*(2), 186–194. doi: 10.1097/NCQ.0b013e31827a4795

Sehgal, N., Green, A., Vidyarthi, A., Blegen, M., & Wachter, R. (2010). Client whiteboards as a communication tool in the hospital setting: A survey of practices and recommendations. *Journal of Hospital Medicine, 5*(4), 234–239.

Tobiano, G., Chaboyer, W., & McMurray A. (2013). Family members' perceptions of the nursing bedside handover. *Journal of Clinical Nursing, 22*(1–2), 192–200. doi: 10.1111/j.1365-2702.2012.04212.x

Wakefield, D., Ragan, R., Brandt, J., & Tregnago, M. (2012). Making the transition to nursing bedside shift reports. *The Joint Commission Journal on Quality and Client Safety, 38*(6), 243–253.