Riding the Current of Innovation to Improve Communication and Patient Safety Using Bedside Report

Presenter:
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Objectives

1. Identify the significant safety benefits of using bedside report as the method of transfer of accountability (TOA).

2. Review strategies to address concerns related to maintaining patient confidentiality and other perceived barriers.

3. Discuss the process used for implementing bedside TOA and recommendations for achieving a successful implementation.
Literature Review

- Safety
- Legislation
- Standards
- Patient Satisfaction
Safety Benefits

1. Structure provided, decreases variability

   a. Standardize report process
   b. What to include
   c. Focus on vital information
2. Patient and staff work together as a team

a. Everyone knows plan of care
b. Contemporaneous information
c. Provide opportunity to ask and respond to questions, interactive:

Provider ↔ Provider
Patient ↔ Provider
Safety Benefits

3. Verify the safety of the patient and their environment

a. Ability of oncoming nurse to visualize patient and prioritize care

b. Accountability between shifts promoted by immediate visualization of patient need by both shifts and throughout shift

c. Limited interruptions

d. Anytime there is a transfer of accountability
Legislation and Standards

Legislation
– Patient access to information

Accreditation
– Encourages clients and families to actively participate in service delivery
– ‘The team transfers information effectively among providers at transition points.’

College of Nurses of Ontario
– Accountability, Relationships, Professional Relationships
Satisfaction

Mutual

• Increased nurse – patient rapport

Staff

• Relationship building between staff members
  – Face to face communication decreases blame
• Facilitates prioritization of workload
• Increases accountability
Satisfaction

Patient Involvement:

- Patient are partners in their care
- More informed about their care
- Know the name and recognize their nurse
- Reduces perception that nurses not around during shift change

Patient Empowerment:

- Increased comfort asking questions and citing concerns

Additional Resource in Diagnosis and Treatment

- Opportunity for patient to correct misconceptions
Catalysts for Change

- Concerns about traditional methods of shift to shift report
- Strategic Direction: Put patients first
- Demonstrate Family Centered Care
- Improve Communication
- Meet Standards
- Improve Efficiency
Efficiencies

• Focus on the patient, elimination of:
  – Lengthy reports
  – Inconsistent information
  – Missing or incorrect elements
  – Irrelevant and subjective comments that may influence the next caregivers perception
  – Lost information when nurse goes home

• Decreased time spent in report and decreased over time costs
Process – Sharing the Plan

- Met with a peer hospital to learn from them
- Advance notice, the rationale, journal articles
- The start date was set
- Huddles were facilitated by the Manager, Education Coordinator, and Team Leader
- Roll play of the process provided
- Staff input encouraged
- Addressed concerns and questions
- Survey Monkey used to decide whether to start 15 min. earlier or start report at end of shift
Barriers Identified and Addressed

- What about patient confidentiality?
- Is it going to take longer?
- What if I have more than one nurse to get report from or give report to?
- What if the patient and/or family have a lot of questions?
- How will it work with the nurses who are always late?
Going Live

- Monday, April 11, 2011, at 0715
- Supportive tools and resources were created and in place
- Manager, Team Leader and Education Coordinator were present during change of shift report (for the entire week) to support the process and answer questions
- All transfer of care report was now done at the bedside
Bedside Report Checklist

- Remind patient, during shift, about bedside report
- Close the door before initiating bedside report
- Allow the patient to choose if they want their family present.
- Introduce oncoming nurse
- Update the white board with the name of the oncoming nurse
- Brief history using SHARE
- Verify ID band while asking the patient to state their name and date of birth
- Check the IV site
- Verify PCA or epidural
- Follow lines to the patient
- Look under the covers
- Check pain score and discuss pain management
- Review all orders and plan of care
- Call bell within reach
- Ask the patient/family if they have anything to add
- DOCUMENT
Example: TOA Tool – SHARE

**S (Situation):**
- Name
- Gravida/Para
- Gestation
- Birth date and time
- APGAR scores
- Complications,
- Physician,
- Baby’s gender
- Birth weight
- Feeding plan
- Last time baby fed

**H (History):**
- Type of birth
- Risk factors
- Hep B, GBS status,
  Rubella
- Primary language,
  translator needed?
- Substance use
- Blood type
- Allergies
- Estimated blood loss
- If C-Section, what was the reason
SHARE

A (Assessment):
- Vital signs and trends
- Catheter
- IV
- Fundas/lochia
- Movement post epidural/spinal
- C-Section: dressing, incision
- Total intake and output
- FHR trends
- Rate of oxytocin

R (Recommendations):
- What to watch for
- Consults needed
- Ask the patient and family if they have anything to add or any questions, “Is there anything I can do for you before I leave?”

E (Extras):
- Update the white board with your name and the time of the breastfeeding class and their discharge date and time
- Obtain clarification
Family Feedback

– “The staff are really caring about me.”
– “My nurse is always asking me if I have any questions, so I have been getting all my questions answered.”
– “[Name] wrote her name on the board, over there, and I like knowing I can call her by name.”
– “It's nice, they didn't do it this way when we had our last baby.”
Staff Feedback

• “I see the benefits of bedside report, I find that I am not coming on to my shift and finding out that things weren’t done, so I like that.”

• “I do like it, I feel that you get a more detailed report, and it is individualized.”

• “I like it, but I find it hard in the mornings when you are giving report and your patient is sleeping, I don’t want to wake them up, especially when they have been up all night.”
Chart Audit Findings

• Random chart audits were performed and the results were communicated to the staff.

• Results:
  - May 2011: 77%
  - June 2011: 72.5%
  - September 2011: 92%
  of charts audited demonstrated that transfer of accountability was done at the bedside.

• Staff who did not document that Bedside Report was given were contacted by the Manager.
Summary:

• Is the right thing to do because it exemplifies excellent care for all

• There are no negative outcomes, only positive patient centered outcomes which enhance the safety of the patient

• The perceived barriers can be overcome with education, practice and support

• Meets the standards defined by Accreditation Canada, the College of Nurses of Ontario, other professional organizations
Questions and Discussion
References


References


References

