

Bringing Change-of-Shift Report to the Bedside

A Patient- and Family-Centered Approach

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Change-of-shift report is the time when responsibility and accountability for the care of a patient is transferred from one nurse to another. The communication that ensues during this process is linked to both patient safety and continuity of care giving. While many nurses already recognize the value of bringing report to the patient's bedside and have practiced in this manner, this remains relatively uncommon. Typically, nurse change-of-shift report has occurred at a nurses' station, conference room, or hallway and may be face to face, audio-taped, recorded on a telephone service, or in a written format. When report is given away from the bedside, the opportunity to visualize the patient and include the patient and family in an exchange of information and care planning is lost. Yet, patients and families, also stewards of patient safety, are given an opportunity to hear and participate in the exchange of information when report is brought to the bedside. Welcoming patients and families into the report process may be a new and challenging process for nursing staff. **Key words:** *Change-of-shift report, patient- and family-centered care, patient safety*

PURPOSE OF CHANGE-OF-SHIFT REPORT

Report is the time when one nurse transfers accountability and responsibility of patients to another nurse. The transfer involves a handoff from one nurse who has observed and cared for a patient to the next nurse who may not know the patient. Report is therefore informational as details about a patient's condition, treatment, and care planning are shared. Report can also be educational, because this time may be used to acquaint the nurse with unfamiliar medications, equipment, or care processes. The communication during this process is intended to insure continuity of care giving and patient safety.

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MEANING OF NURSE CHANGE-OF-SHIFT REPORT

In addition to the purpose of report, it is important to acknowledge the meaning of report for the nurse. The personal meaning of report may underlie staff willingness to welcome patients and families during report. First, report can have emotional meaning for the nurse. It is a time to connect with other staff and share the emotional distress and struggles endured over the course of a shift. We nurses may take this time to complain about other staff, patients, or their families. Second, report may be a time when we socialize with one another, sharing updates on the personal lives of our colleagues and ourselves. It is not unusual during report to learn of life events such as births, marriages, or vacation adventures.

THE PROCESS OF REPORT

Change-of-shift report may be verbal or written and given in a group or individualized format. In a group

format, report on all patients is shared with the nurses of next shift, often by the previous charge nurse. The report from the previous shift may be taped and available for listening. Report may also be individualized where the patient's nurse gives report to the oncoming nurse assigned to the patient. Typically, change-of-shift report occurs at the nurses' station, in a conference room, or the hallway, away from patients and families. Certainly, the process has not traditionally included patients and families and, in fact, "visiting" hours may be restricted during change of shift. Families are often asked to leave the patient's room or unit during this time.

THE NEED FOR CHANGE

The Institute of Medicine in its landmark publication in 2001¹ highlighted the problem of patient safety and, subsequently, efforts have been made to improve care to avoid errors. There is an impetus to involve patients and families in care to improve safety and quality.²⁻⁸ The Institute for Health Care Improvement collaborated with the Robert Wood Johnson foundation and created an initiative titled "Transforming Care at the Bedside" to improve patient safety.⁸ This initiative includes bringing report to the bedside.

Errors may occur because communication is faulty. Two Joint Commission National Patient Safety Goals⁷ address patient safety issues that may be encountered during change-of-shift report.⁹ First, patient involvement in care is encouraged as a patient safety strategy and it is also recommended that a family member or trusted friend should be an advocate when the patient is unable to speak for himself or herself. These National Patient Safety Goals can be applied during the process of change-of-shift report. Patients and their families, if desired by the adult patient, should be involved in the communication processes related to their care planning. In addition to the patient and family's need for information, partnering with patients or families at the bedside during report is a patient safety strategy.¹⁰

APPLYING THE PRINCIPLES OF PATIENT- AND FAMILY-CENTERED CARE TO THE REPORT PROCESS

There are 4 core concepts of patient- and family-centered care as described by the Institute for Patient and Family Centered Care¹¹: (1) respect and dignity; (2) information sharing; (3) participation; and (4) collaboration. The goal of patient- and family-centered care is to improve the experience of care through mutually

beneficial partnerships. Change-of-shift report offers an opportunity to improve the experience of care by partnering with patients and families.

Respect and dignity requires that nurses honor patient and family perspectives and choices. When we plan and deliver care, it is of paramount importance to incorporate patient and family knowledge, values, beliefs, and cultural backgrounds. It is also important that we respect all patients and families as partners to insure that their perspectives are heard and valued. Often, we strive to create partnerships with those patients and families that we "like" or that are most "like us," giving less attention to patients or families we find more challenging. We must strive to overcome these tendencies for the safe and satisfying care of all patients. During the report process, we must strive to clearly communicate and create meaningful partnerships with all patients and families. It is during report that we explain and plan care and we need patient and family input to insure care is delivered in ways that can work for everyone.

Complete and unbiased information is shared with patients and families so they are able to participate in care and decision making. Report is the time when important information about the patient's condition and treatment is shared. In fact, the nurse may have information that the patient does not know and the patient or the family may have information not yet shared with the nurse. When nurses partner with patients and families during report, appropriate and useful information sharing is maximized.

In patient- and family-centered care, patients and families are encouraged and supported to participate in care and decision making at the level they choose. Adult patients must determine who should be involved in the report process. When patients and families (as defined by the adult patient) are invited to be active participants in report, it is important to remember that the level of participation may vary from patient to patient and family to family. The level of participation may also vary from day to day depending on the patient's physical and emotional state. Staff must develop a mechanism to determine if patients or their families wish to be awakened and involved in all of report. Families often have competing home and work responsibilities and may not be present for all change-of-shift reports. Therefore, the amount of involvement in report must be individually determined. The nurse can define roles to increase patient and family comfort in the process. Some patients or families may be reluctant to be active participants in the report process. Yet, we should encourage their input, as it is valuable to safe care. "Tell us how your pain is." "Tell us how much you walked

today.” In the neonatal unit parents can describe their infant’s responses to care, how the baby has fed, and how they are feeling in terms of their confidence and competence with care.

Collaboration is the final concept of patient- and family-centered care. This collaboration occurs in policy and program development, implementation, and evaluation, in professional education, as well as in the planning and delivery of care. Experienced patients and families can offer advice, support, and education for staff or other patients and families about the report process. Patients and families can help develop informational materials about report for other patients and families. They can strategize with staff to teach and support nurses as the new report process evolves.

Patients and families can contribute to standardized report or handoff tools that are developed. Are there aspects of care important to patients and families that the nurses have not considered? Typically, staff concentrate on technical aspects of care giving. Yet, nontechnical aspects of care giving are also important. Patients and families can help evaluate the report process and handoff tools to identify information that should be included in report. For example, it may be important to include in a handoff tool when the family will be back to be with the patient so that teaching, care giving, or information sharing can be appropriately arranged.

CHALLENGES OF BRINGING REPORT TO THE BEDSIDE

Breaking the traditional routine for report is a challenge. Although patients and families are stewards of safety and the care experience, with limited exceptions, their input in report is just recently being sought. Since nurses usually conduct report and exchange patient information at the nurses’ station, bringing report to the bedside requires a practice change and may also require a psychological adjustment because of the meaning of report time for nursing staff. Nurses face several challenges when bringing report to the bedside and engaging patients and families in the exchange of information.^{9,12,13}

We may work in environments that are not conducive to privacy. Many patients are hospitalized in semiprivate rooms or wards. Nurses are concerned that if report is brought to the bedside then other patients or families will overhear confidential information. Certainly, hospital rooms were not originally built to respect patient privacy, but increasing concern regarding privacy can be a barrier to patient and family participation during report. The units in which we work should

not prevent us from welcoming patients and families as important team members in care planning and decision making, particularly when it can contribute to patient safety.¹⁴ The truth is that confidential information is inadvertently disclosed throughout the day when staff and physicians have discussions with patients and families. These disclosures are not intentional but rather a consequence of patients sharing hospital rooms or common spaces. In fact, it may be during processes, such as report, that we are most cognizant of who is in the patient’s room.

To address concerns about patient confidentiality, it may be desirable to discuss the possibility of these incidental disclosures with patients and families during the admission process and orientation to the unit. At this time, the adult patient or parent(s) of a neonate can disclose who, if anyone, they would want to participate in change-of-shift report. We can underscore our determination to partner with patients and their families to provide safe, quality, and satisfying care. Consider a written philosophy of care that acknowledges the importance of patient and family access to information. The philosophy of care in the organization must affirm the relationship between outcomes and patient and family participation in care planning and decision making. This discussion could be part of a general consent form utilized in units.

Another concern for nurses in bringing report to the bedside is the issue of sensitive topics or new information not yet shared with the patient/family. These issues may be used to justify traditional styles of report. Report can and must still be given at the bedside. However, the nursing staff can plan ahead so that sensitive or new information is shared before or after the bedside report. For example, if the infant has had an intraventricular hemorrhage and the neonatologist has not yet met with the family to discuss the findings, the nurses can share this information privately before or after approaching the bedside. If written reports are shared, this information could be noted there. The goal is to modify staff behavior so that patients and families can be included in the report process.

Another concern regarding involvement of patients and families in report is that it will decrease the nurses’ efficiency resulting in overtime hours or threaten patient safety. Nurses must learn negotiation skills to meet the needs of patients and families and the safety of the patient. For example, “Mrs. Smith, great question. Let Becky and me check all these drips so we don’t make a mistake, and then I’ll answer you.” “Mrs. Smith, I would like to talk to you more about that. Can I come back after Becky and I complete report on our other patients?” In fact, report at the bedside may actually save

time.^{9,12,13} In part, this may relate to the nurses being able to focus on the patient and report rather than on social or emotional issues. The use of a report template standardizes the information to be given and may lessen communication variability in report.¹⁵ There is additional potential to save time over time, when the patient and equipment are visualized with both nurses. This provides nurses with the opportunity to clarify and correct inaccuracies with the patient and family, and of the nurse ultimately decreasing errors.

Nurses may resist welcoming families at the bedside during report because report time is utilized as a “break” from the family. In many units espousing 24-hour-a-day “visitation,” families are not welcome to be with the patient during report. Certainly, all workers need a “break” from their work, and we must support one another to take a break when needed. However, this break must not be during change-of-shift report. The family has a right to be with their loved one and a right to know the plan of care and exchange of information. The family’s observations and contributions can be valuable to care of the patient. The family is a steward of patient safety and, as a welcome participant in report, can be an asset to the care environment. Value of family support, information sharing, and patient care giving transcends report time. Therefore, families should not be excluded from the unit when change of shift occurs.

Nursing staff may resist bedside report believing that it will preclude obtaining knowledge on all the patients in their unit. An example of how this can be addressed is in the beginning of each shift the nurses can meet and receive a 5- to 10-minute overview of the unit’s patients. This part of report could occur at the nurses’ station or in a conference room and involve nursing staff only. A limited amount of information can be shared including (a) basic diagnoses of all patients; (b) safety issues; and (c) care issues that all may need to know. After this overview, individual nurses give a detailed report in the patient’s rooms, sharing what has occurred during the shift, the plan of care encouraging and welcoming the patient and family to share in the discussion. During report, there is a safety check of fluids, intravenous sites, intravenous pumps, drains, medications, etc.

BENEFITS OF BEDSIDE REPORT

There are several benefits to giving report at the bedside.^{9,12,13,16} Certainly, patients are seen sooner in the shift and the nurse leaving can introduce the patient to the oncoming nurse. When we share information at the bedside with the patients and families,

the patients are seen holistically, not just as a diagnosis and treatment plan. Patient and family members witness staff communication, professionalism, and organization as responsibility is transitioned to another nurse.⁹ Patients also feel a part of report and appreciate having input. Welcoming the participation of patients and families offers them an opportunity to participate in the exchange of information. This will insure that the staff, patient, and family all have knowledge of the treatment plan. Patients and families like and need to know the plan of care to be able to contribute to decision making and plan, for example, for transitions in care such as discharge to home.

When report is given at the bedside with the patient and family, the nurses are able to receive information from the patient and family as they provide an additional resource for diagnosis and treatment. Patient and family participation may prompt recall of events and issues and clarify misinformation that is shared during report. There is an opportunity to acknowledge and act on patient or family observations. When nurses speak with the patient and family, they are given an opportunity to incorporate their observations and desires into the plan of care.

Nurses recognize the education that can occur during report and this extends to patients and families who can receive new information along with the staff. There may be new medications or treatments for the patient. Another key component of education is the opportunity to role model communication to another nurse who may have less experience.

STAFF, PATIENT, AND FAMILY SUPPORT AND EDUCATION OF THE PATIENT- AND FAMILY-CENTERED REPORT PROCESS

When report templates are developed, nontechnical topics should also be included. Staff can work with patients and families for input to determine what other aspects of care should be included in the report template. In the neonatal intensive care unit, it can be beneficial to include when parents plan to come to be with their baby and what care they want to give, which can be conveyed to all staff. For example, parents may plan to come in to feed their baby, but this information is not conveyed to the oncoming nurse. When the baby is fed earlier and is sleeping when the parents arrive, they may feel angry and disappointed. If parents’ plans for care giving are routinely documented, these unplanned situations can be avoided.

As with all new equipment and processes, nurses must be engaged in development and provided with

education. Attention to communication skills that address specific concerns and fears must be included. For example, if the nurse is giving report at the bedside and realizes she has made an error, how will this be communicated? Patient and family advisors can provide education and support about communication skills for the nursing staff in these situations. Perhaps, the new report process could be a mandatory competency.

Education and support of the staff must be ongoing. Resources must be readily available in a manner similar to when new equipment is introduced. A change in the report process must not be a one time educational opportunity. There needs to be continued follow-up and evaluation to allow for improvements.

Report often requires a repetition of information that can be frustrating for patients or families.⁹ The nurses must explain the necessity of the repetitive information. Just as with a systematic physical examination, we do not want to forget anything important. We can ask the patient or family to identify any inaccuracies. Report should end by asking the patient or family if there are any concerns about safety.¹³ It is important to reiterate that we want to work together to make certain the patients have what they need.

Patients and families must be oriented to the report process when they are admitted. The nurse can explain the value of their participation in report and work with the patient/family together to determine if all of the report should be conducted at the bedside or just the final safety check when the patient is sleeping. An evaluation of the benefits of participation in report can be solicited from patients and families when nurse leaders make rounds or discharge phone calls. Patients and families can be asked if they participated in report and to identify what worked well and what ideas they have

for improvement. Their evaluation can serve to make the process better.

A beginning step for unit leaders could be to solicit nursing staff opinions, concerns, and experiences with bedside reports. The challenges noted above can serve as a baseline. Nurses should be encouraged to express their worries before initiating the new process. Role-playing to address these particular situations can prepare nurses for responding to uncomfortable situations. Patient and family advisors can be asked to share their report experiences and if they are able to identify potential improvements in care with an active role in the report process. If formal advisors are not yet available in the organization, a focus group of parents in the neonatal intensive care unit or former adult patients could be convened to discuss experiences regarding change-of-shift report. Patient and family stories are very powerful tools to effect change. Patients and families are experts in the experience of care and can be catalysts for practice improvements.

CONCLUSION

The goal of patient- and family-centered report at the bedside is to improve the information shared to benefit patient safety and the care experience. The goal is partnership, not transfer the traditional report style to the bedside where only medical jargon is used and the staff “talk over” the patient and family. The medical record or computer should not be the sole focus of communication. Information must be exchanged among both nurses, the patient, and the family. Patients and their families are our partners; they are essential to safe and quality care. Therefore, we must welcome families 24 hours a day, not 24 hours minus change-of-shift report.

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