

A Practical Guide to the Implementation of Bedside Report in a Critical Care Setting

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Blended bedside report increases peer-to-peer accountability among nurses, improves communication between nurses as well as patients, and promotes patient safety. Despite the literature that documents bedside report is best, a practical guide to initiating this process in a hospital setting is lacking. A unit-based council composed of staff nurses and 1 member of nursing management on a neurosurgical intensive care unit designed a unit-wide education initiative involving multiple modalities and peer-to-peer training. This combination led to a successful culture change from traditional report to blended bedside reporting process. **Key words:** *bedside report, blended bedside report, handoff, implementation of bedside report, peer-to-peer training*

IN a complex health care setting such as a critical care unit, the communication of pertinent patient information and the transfer of nursing responsibilities between caregivers is an essential component of patient safety. With medical errors reported as the third leading cause of death, and miscommunication identified as a contributor to harm in 80% of medical malpractice

lawsuits,¹ a standardized form of report is in the best interest of both the nurse and the patient. Since 2005, The Joint Commission has addressed the failure in communication between health care providers by making implementation of a standardized approach to hand off communication a National Safety Goal. This institutional approach should allow staff the opportunity to ask questions and respond to them.¹ This communication has been identified by many names: bedside report, handoff, sign-out, and shift report.

It is proven that “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.”¹ Despite its importance to patient safety, nurses have been resistant to participating in bedside report, citing patient confidentiality, increase in report time,¹ and frequent interruptions by patients.² It is challenging for institutions to have the nurse endorse bedside reporting. Faced with patient safety goals and overwhelming evidence that bedside report is beneficial to patient safety,³ institutions have implemented policies and procedures for care transitions, but little research has

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been done on the best practice for utilization of this process. This article details the implementation of a standardized bedside reporting process in a large teaching hospital in a 22-bed neurosurgical intensive care unit (ICU) by a unit-based council consisting of bedside nurses and a member of nursing management.

WHY BEDSIDE REPORT?

Bedside handoff, bedside report, and shift-to-shift report can all be defined as a critical transition of care. This is a time when essential information about the patient is exchanged between nurses as well as the responsibility of caring for the patient. This interaction between nurses must include the opportunity for questioning between the giver and receiver of information.⁴ There are several different types of report, including traditional, bedside, and blended. The traditional report consists of a face-to-face handoff that takes place in a private setting away from the patient's bedside. Bedside report is essentially a shift report that is solely conducted at the patient's bedside. Blended report occurs when half of the report is conducted face-to-face in a private setting and the other half is conducted face-to-face at the patient's bedside.⁴

Advantages to blended report include increased nursing accountability, teamwork, report accuracy, enhanced patient care/transition of care, and increased patient as well as nurse satisfaction. The blended report approach also alleviates nursing fears of exchanging sensitive information at the bedside and frequent patient interruptions during critical information exchange.⁵

CURRENT CONDITION

During a period of turnover with a large influx of new nurses joining the neurosurgical ICU, staff began to become dissatisfied with inconsistencies in the amount of information exchanged in report, nonstandardized organization of information, and lack of cleanliness

of patient's rooms. While speaking with staff, the unit-based council realized that there was no standard for shift report or hand-off. Staff reported an education/knowledge deficit on bedside reporting and the absence of concrete expectations for report. The unit-based council believed that nursing satisfaction, communication between staff and patients, and patient safety could all be improved by researching and implementing an evidence-based practice shift report.

Taking on a project of this size can be overwhelming, so devising an organized approach was a key to success. First, the team conducted a thorough literature review to ensure that the new standards developed would be based upon best practice. The literature not only informed on evidence-based practice but also allowed the unit-based council to see that research on implementing bedside report was lacking. After an evaluation of all 3 distinct report types, blended report was chosen as the model to structure the new bedside report process.

Blind observations, a presurvey and casual conversation with staff members confirmed that while bedside reporting was regarded as valuable to nurses, there was a need for a standardized process of giving bedside report. The unit-based council created several forms to outline what information was expected to be communicated during bedside report, and the order in which that information was to be relayed. A 3-pronged unit education was then developed to engage all types of learners (visual, auditory, and kinetic). During unit education, the importance of bedside report was reviewed and the new standardized bedside report process was introduced to staff members. Thirty and ninety days following implementation, an evaluation of staff participation and attitudes of staff members were conducted to determine the success of the project.

THE PRESURVEY

Before devising a unit-wide standard for bedside report, an anonymous presurvey was

distributed to gauge nurses' perceptions of bedside report. Six questions were asked using a 5-point Likert scale, simultaneously 2 third-party observers (a unit secretary and respiratory therapist) conducted blind observations of RN shift handoff and recorded the number of RNs who went into the patient's room and completed bedside report. Ninety-five percent of nurses believed that bedside report promoted patient safety and 73% of the nurses stated that they always or usually complete bedside report. While in reality, our observers recorded that the nurses were only executing bedside report 34% of the time. The other 66% of the time, nurses were using a traditional report model and only exchanging information outside the patient's room. See Table 1.

STANDARDIZATION OF FORMS

The next critical step in defining the blended bedside report process was to design a set of standardized forms that detailed

what information was to be exchanged during report and where this exchange was to take place. The first form created was the bedside report checklist; it was a guide to follow each time report was given. The checklist entailed an outline that separated the blended report into 3 specific areas: a handoff outside the patient's room, a patient safety check, and a room/environment assessment. The bedside checklist was posted outside of each report station so that it could be easily referenced during report. The staff was educated on the checklist contents during peer-to-peer education.

The outside handoff was composed of items that should be discussed away from the patient such as code status, history, summary of present admission, plan of care, physical assessment, and family issues. The expectation outside of the patient's room also included accessing the patient's electronic chart to quickly review active orders, electronic medication record, laboratory results, and work list.

Table 1. Presurvey Results^a

Question	Presurvey Results by Percentage				
	Always	Usually	Sometimes	Rarely	Never
How often do you complete bedside report?	26%	47%	24%	3%	0%
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Does bedside report promote accountability and sense of ownership in your practice?	50%	42%	8%	0%	0%
Does bedside report provide peer-to-peer learning opportunities?	45%	45%	5%	5%	0%
Do you think standardized bedside report tools increase length of report time?	13%	29%	47%	8%	3%
Do you believe bedside report promotes patient safety?	50%	45%	5%	0%	0%
Does standardized report increase efficiency and communication between nurses?	45%	24%	21%	10%	0%

^aSource: Neurosurgical ICU Unit Based Council.

The patient safety check outlined what actions/assessments would be completed at the patient's physical bedside. Starting with an introduction of the new caregiver, this check would then progress to a brief neurological assessment and the review of tubes, drains, drips, and other devices. It was expected that the placement of all tubes and drains be verified by both RNs, for example, endotracheal (ET) tube, orogastric or nasogastric tube, external ventricular devices (EVDs), Jackson-Pratt and lumbar drains, chest tubes, vascular access, and urinary catheters. All continuous medication drips were to be checked to ensure that the correct concentration, rate, and weight were programmed accurately into the pump. At this time any abnormal findings such as skin issues, incisions, or negative pressure wound therapy pump were also to be verified.

One of the most common issues RNs reported was that patients' rooms were left with unused supplies scattered around and trash was left on RN workspaces. Adding a room environment section to the checklist gave RNs an opportunity to address this issue constructively. During this portion, whiteboards were to be updated, fall precautions

such as bed alarms, side rails, fall band, and call light were to be double checked as well as verifying the presence of adequate supplies such as pads, linen, mouth care kits, and tube feeds. See Form 1.

The second document developed was a standardized report sheet. This defined the information to be conveyed during the physical assessment, creating a higher level of efficiency and consistency in the information exchange. Structured from a collection of handwritten report sheets on the nursing unit, this sheet was available on the unit but not required for use by all nurses. The physical assessment began with the neuroassessment, and then progressed to respiratory, cardiovascular, gastrointestinal, genitourinary, and skin assessments. As this was created for a neurosurgical ICU, much of the report sheet was devoted to the neuroassessment. Emphasis was placed on the content of the neuroassessment as well as the order of this information. The unit's expectation was that the neuroassessment would begin with level of consciousness, and then move to eyes, speech, protectives, extremities, sensation, drains, and National Institutes of Health Stroke Scale/Score.

Bedside Report Checklist		
Outside Handoff	Patient Safety Check	Room Environment
<ul style="list-style-type: none"> <input type="checkbox"/> Code status <input type="checkbox"/> Primary service <input type="checkbox"/> Allergies <input type="checkbox"/> History <input type="checkbox"/> Present admission synopsis <input type="checkbox"/> Plan of care <input type="checkbox"/> Physical assessment <input type="checkbox"/> Reconcile orders <input type="checkbox"/> Check labs <input type="checkbox"/> Review MAR <input type="checkbox"/> Check work list <input type="checkbox"/> Discuss any family issues 	<ul style="list-style-type: none"> <input type="checkbox"/> Introduction <input type="checkbox"/> Neuro assessment <input type="checkbox"/> Oxygenation/vent settings <input type="checkbox"/> Check placement tubes/drains <ul style="list-style-type: none"> <input type="checkbox"/> ET tube <input type="checkbox"/> OG/NG tube <input type="checkbox"/> EVD <input type="checkbox"/> JP drain <input type="checkbox"/> Lumbar drain <input type="checkbox"/> Chest tube <input type="checkbox"/> Foley <input type="checkbox"/> Access <ul style="list-style-type: none"> <input type="checkbox"/> Patency <input type="checkbox"/> Dressing <input type="checkbox"/> Medication Drips <ul style="list-style-type: none"> <input type="checkbox"/> Concentration <input type="checkbox"/> Rate <input type="checkbox"/> Pump programmed correctly <input type="checkbox"/> IV tubing <input type="checkbox"/> Abnormal findings <ul style="list-style-type: none"> <input type="checkbox"/> Skin issues, incisions 	<ul style="list-style-type: none"> <input type="checkbox"/> Update whiteboard <input type="checkbox"/> Day vs night bath <input type="checkbox"/> ID and allergy band <input type="checkbox"/> Fall precautions <ul style="list-style-type: none"> <input type="checkbox"/> Fall band <input type="checkbox"/> Bed alarm <input type="checkbox"/> Side rails <input type="checkbox"/> Call light <input type="checkbox"/> Adequate supplies <ul style="list-style-type: none"> <input type="checkbox"/> Pads <input type="checkbox"/> Bath supplies <input type="checkbox"/> Washcloths <input type="checkbox"/> Extra set of linen <input type="checkbox"/> Tube feeds <input type="checkbox"/> Mouth care kit <input type="checkbox"/> Overall room cleanliness

Form 1. Bedside report checklist. *Source:* Neurosurgical ICU Unit Based Council.

The standardized report sheet was mainly utilized by newer nurses or nurses still on orientation but was introduced to all nurses during the peer-to-peer education. The expectation was that all information would be presented in the order outlined on the standardized report sheet. It was not mandated that all nurses use the sheet, as long as those who did not use it were able to give report in the correct order. See Form 2.

Finally, an existing hospital-wide patient clinical summary sheet, already familiar to the staff, was utilized that detailed basic patient information such as physician service, code status, chief complaint, allergies, and patient stay synopsis. This sheet was initiated at the patient's admission to the hospital and was passed between RNs at every shift change and even followed the patient to other units throughout their treatment course. It offered the nurse the ability to have a brief record of important clinical events and to update the plan of care after each shift. The patient summary sheet allowed RNs to get an idea of the



details of the entire patient's stay in a short amount of time. During bedside report education it was reinforced that daily entries should be concise and limited to pertinent information only, thus increasing efficiency of report time. See Form 3.

INITIAL EDUCATION

Change of shift huddle (a brief meeting conducted with both shifts to exchange important unit information) created an excellent platform to introduce background education and important safety statistics relevant to bedside report. Appealing to both auditory and visual learners, 2 sunflower-shaped structures were created with each petal highlighting a bedside report pearl. Staff was asked to read 1 petal at each morning huddle over a 2-week period and received a small reward was promised to encourage engagement. After each petal was read, it was then placed on a centralized display board for all staff, patients, and family members to

<p>Name _____ Age _____ Primary service _____ Code Status _____</p> <p>Admission _____</p> <p>History _____</p> <p>Admission Synopsis _____</p>	
<p>NEURO</p>	<p>Level of consciousness: GCS: E: _____ V: _____ O: _____</p> <p>Baseline: _____</p> <p>Alertness: _____</p> <p>Pupils: _____</p> <p>Motor: _____</p> <p>Sensory: _____</p> <p>Reflexes: _____</p> <p>Drain: _____</p> <p>Wound: _____</p> <p>Pain: _____</p> <p>Other: _____</p>
	<p>CARDIOVASCULAR</p> <p>Rate: _____</p> <p>Rhythm: _____</p> <p>BP: _____</p> <p>ECG: _____</p> <p>Medications: _____</p> <p>Other: _____</p>
	<p>GASTROINTESTINAL</p> <p>Appetite: _____</p> <p>GI: _____</p> <p>Stool: _____</p> <p>Urine: _____</p> <p>Other: _____</p>
	<p>GENITOURINARY</p> <p>Urinary: _____</p> <p>Other: _____</p>
	<p>SKIN</p> <p>Wound: _____</p> <p>Other: _____</p>
	<p>RESPIRATORY</p> <p>SpO2: _____</p> <p>RR: _____</p> <p>CPAP: _____</p> <p>Other: _____</p>
	<p>GENERAL INFO</p> <p>Code: _____</p> <p>Other: _____</p>
	<p>NEURO ICIU REPORT SHEET</p>
	<p>ADMISSION SYNOPSIS</p>
	<p>ADMISSION SYNOPSIS</p>

Form 2. Standardized report sheet. *Source:* Neurosurgical ICU Unit Based Council.

 <p>Nursing Hand-off Report Sheet-Patient Summary (Not a permanent part of the patient record; to be used as guide for bedside reporting)</p>		 <p>Nursing Hand-off Report Sheet-Patient Summary (Not a permanent part of the patient record; to be used as guide for bedside reporting)</p>	
SITUATION			
Patient Name: _____ DOB: 9/17/1957 - 61 y/o			
Room: 741 Admission Date: 1/11/11		Attending Physician: Neurology	
Admitting Diagnosis: DPH		Chief Complaint: _____	
Consulting Physician(s): Neurology			
Allergies OR Allergies (Specify): _____			
Armbands: <input checked="" type="checkbox"/> Patient Identification <input type="checkbox"/> Allergy <input type="checkbox"/> Fall Risk <input type="checkbox"/> Limb alert <input type="checkbox"/> Bloodless medicine			
Code Status: <input checked="" type="checkbox"/> Full Code <input type="checkbox"/> DNR <input type="checkbox"/> Limited (Specify): _____		POLST: <input type="checkbox"/> One Day	
Isolation QMC: <input type="checkbox"/> Yes <input type="checkbox"/> No		Admission Weight: _____ kg Height: _____ cm	
BACKGROUND		LOS ROUNDS UPDATES/ISSUES/RESOLUTIONS (e.g., anticipated patient condition for discharge, internal transfer/external disposition, palliative care consult)	
Past Medical/Surgical History (Circle if applicable): Arythmia Asthma CAD/Angina Cancer CHF COPD CIA Diabetes DVT Emphysema GERD GI Bleed Hypertension (HTN) Hypertrophic Cardiomyopathy (HCM) Hyper/hypothyroidism MI Pneumonia Renal failure		Initial Date	
C/Other (Specify): _____		_____	
_____		_____	
Psychosocial History: DHS Problems Chx Smoking Wtc ETOM Dts Drug		_____	
C/Other (Specify): ALLERGIC ANIMAL - 2-X HYPERLIPIDEMIA		_____	
Family Contact: _____		_____	
Phone: _____		_____	

Form 3. Nursing hand-off report sheet patient summary. Source: Neurosurgical ICU Unit Based Council.

view. This allowed 14 members of the staff to become fully engaged in the initial process.

In addition to the huddle blasts, copies of an article relevant to bedside report were posted on the display board for staff to read and complete a short quiz. This form of education was chosen to draw in a more visual but introverted learner who may not have had the courage to participate in the more public huddle blasts. The article chosen, “Off to a Good Start: Bedside Report,”⁶ was brief and contained a relevant case study about an intensive care nurse’s experience with bedside report saving a patient’s life. Staff completing the article quiz were entered in a nominal gift card drawing. This form of education was voluntary and engaged another 8 members of the staff prior to the mandatory hands-on training.

DEVELOPMENT OF A PEER-TO-PEER HANDS-ON TRAINING

Six staff nurses were chosen by the unit-based council as bedside report champions

to further engage the unit staff in bedside report education. These 6 nurses were strategically selected to encompass all levels of the novice to expert paradigm; 2 expert nurses (greater than 10 years in the ICU), 2 middle nurses (4-5 years in the ICU), and 2 new nurses (1 year or less experience in the ICU) comprised this group. In addition to their experience levels, these nurses were identified as social group leaders on the unit and thus could influence large portions of the staff by their involvement in the project. Each of the 6 champions received a letter detailing their role and responsibilities documenting their participation in the project for their professional portfolios.

The bedside report champions attended a 4-hour class in which they were taught the new blended bedside report process and the concept of a hands-on peer-to-peer training. By choosing champions from the staff, the bedside report process evolved from a management-centered mandate to a nurse-driven initiative. The nurse champions then partnered with the unit-based council

team members to train the rest of the staff.

Inspired by the case study selected for the initial education training, the hands-on or kinetic learning experience needed to appear realistic and applicable to bedside nursing practice. Mock scenarios were constructed based on previous patients admitted to the unit and were composed of a patient summary sheet, a bedside report sheet utilizing the standardized report form, and a bedside checklist. The checklist was constructed for the use of the champions with discrepancies highlighted in red that differed from the verbal report given. Therefore, the importance of a bedside check was highlighted to increase patient safety and decrease human error.

Each training scenario was composed of an untrained staff member (receiver of report), a champion (giver of report), and a mock patient staged in an empty bedside, played by another champion or unit-based council member. The expectation of the hands-on

training was that every staff member received a bedside report from a champion including the introduction/education of the standardized report sheet, patient summary, and bedside checklist forms. The pair proceeded into the room to complete a bedside safety check and discover the discrepancies from the verbal report. Afterward a debriefing occurred of the experience and discussion of the impact of a bedside report.

To aid in the mock patient setup, a tool kit was constructed containing lines, drains, intravenous (IV) tubing and solutions, and a pair of IV pumps that could be programmed with drip rates. An example of 1 item used was an ET tube cut and placed in a holder at an inaccurate measurement that could be placed on the mock patient. Another was a medication drip infusing into a test tube taped to the mock patient's wrist; this drip would be programmed to infuse at the wrong rate and patient weight. A complete list of the toolbox items and their utilization in the mock scenario can be found in Table 2.

Table 2. Mock Scenario Toolbox^a

<p>Heparin, nicardipine, propofol, hypertonic saline, norepinephrine drips</p> <ul style="list-style-type: none"> • Drip running at incorrect rate • Wrong weight entered into IV pump • Drip running that was supposed to be on hold • Incorrect concentration of drip (eg, norepinephrine 16 mg in 250 mL instead of 4 mg in 250 mL) • IV tubing expired <p>Subclavian central line, PICC line, arterial line, peripheral IVs</p> <ul style="list-style-type: none"> • Line was at incorrect measurement length • Line on right side instead of left (or vice versa) • Dressing out of date <p>Endotracheal tube, OG/NG tube</p> <ul style="list-style-type: none"> • Tube length was a different number • Tube size was incorrect <p>EVD drain</p> <ul style="list-style-type: none"> • EVD was at incorrect level • EVD was clamped instead of opened <p>Soft restraints, mitts</p> <ul style="list-style-type: none"> • Restraints applied to incorrect limb • Restraint order expired <p>ID band, allergy band, fall risk band</p> <ul style="list-style-type: none"> • Band was not present when supposed to be

Abbreviations: EVD, external ventricular device; ID, identification; IV, intravenous; OG/NG, orogastric/nasogastric; PICC, peripherally inserted central catheter.

^aSource: Neurosurgical ICU Unit Based Council.

Scenario Example

Full report was given by the RN champion or unit-based council member from start to finish outside the room and accompanied by a bedside assessment. This was designed to take approximately 15 minutes, corresponding to half of a standard 2-patient ICU assignment. During traditional (verbal) report outside the room, it was communicated to the receiver of report that the patient was localizing with the right upper extremity (RUE), ET tube was at 24 cm, the EVD was open at 5 mm Hg, the peripherally inserted central catheter (PICC) was at 0 cm at the skin, the hypertonic saline drip was on hold, and the patient was wearing a fall band. Upon entering the mock patient's room for bedside assessment, the goal was for the receiver of report to notice that the patient was withdrawing with the RUE, the ET tube was actually at 22 cm, the EVD was open at 0 mm Hg, the PICC was at 5 cm at the skin, the hypertonic saline drop was running, and the patient was missing a fall band.

If the receiver of report did not note all changes, it was remediated in the short debriefing session after the training scenario ended. This provided yet another demonstration of how blended bedside report could reduce medical errors. Four different scenarios were constructed based on actual patient situations where important aspects of care were overlooked. One scenario was randomly selected for use by the RN champion/unit-based council member to prevent staff from sharing scenario answers. Scenarios could be adapted and customized for individual unit's specialty assessments and considerations.

Unit-wide education began with 2 weeks of daily huddle blast facts and the optional case study article and then progressed to 3 weeks of hands-on mock scenarios with a mock patient and RN champion. After over 90% of staff had completed the hands-on training of blended bedside report, the unit-based council considered bedside report fully implemented in the neuro-ICU. The expectation for the RNs was that they would complete a blended bedside report 100% of

the time. It took approximately 5 to 6 weeks to complete the entire training process.

EVALUATION

Staff resistance to change and length of time required to train all staff RNs were the 2 biggest barriers faced by the unit-based council. The presurvey indicated that almost all RNs believed blended bedside report was better for patient safety, but only one-third of these RNs were actually practicing blended report. The goal during the process change was not just to tell the RNs about the new process, but rather demonstrate with research and concrete evidence why blended bedside report was the best possible modality. Since the team was able to demonstrate that the literature proved blended bedside report was superior before implementation, staff resistance was not as great a barrier as initially presumed to be.

Very few nurses expressed issues with the new process, and the ones who did were mainly concerned with the amount of time that blended report would add to shift change. Immediately after implementation some staff reported an increase in report time, but after staff became more familiar with the blended process, report times decreased. By the 19th-day postimplementation mark, report times had returned to 25 to 30 minutes, approximately the same amount of time it took to give report before the blended process was introduced.

Another barrier to blended bedside report implementation was the time that it took for all staff RNs to be trained and signed off on the hands-on portion of the unit-wide education. Staff RNs all had to be trained during their scheduled shifts; this proved difficult when staff RNs were busy with their assigned patients and unable to step away for bedside report training. The unit-based council attempted to combat this barrier by designating a time for each staff RN to be trained and by asking the charge nurse to cover the staff RN's patients during this time. While in theory this was an adequate solution, charge

nurses often had an assignment of their own and were unable to cover a second assignment at the same time. In an ideal world, all RNs would be able to attend the blended bedside report training before being assigned to patients.

Thirty days after the blended bedside report project was implemented, third-party observers (the same unit secretary and respiratory therapist) again audited shift change report and RN compliance with blended bedside report had increased to 80% from 34%. At the same time, the team also conducted a 1-month postsurvey to reassess the RN's attitudes toward bedside report. The survey again was anonymous and consisted of 7 questions with a Likert scale and 1 open-ended question. When asked whether adequate education was provided to facilitate bedside report, 93% of nurses chose either strongly agreed (53%) or agreed (40%). One

hundred percent of nurses surveyed stated that they strongly agreed (80%) or agreed (20%) that blended bedside report promotes patient safety. One year after implementation, a final audit of compliance was conducted by the same third-party observers and 94% of nurses were performing bedside report. See Table 3.

Although all parts of this improvement process were valuable in changing and influencing the performance of bedside report, it was the belief of the implementation team that the entirety of the process was what led to a successful cultural change. Other units in the same hospital adopted some portions but not the entire process and did not reach the same desired results.

The culture change extended beyond the borders of the neurosurgical ICU. The blended bedside reporting process was recognized by both float pool nurses and nurses

Table 3. Postsurvey Results^a

Question	Postsurvey Results by Percentage				
	Always	Usually	Sometimes	Rarely	Never
How often do you complete bedside report?	53%	47%	0%	0%	0%
	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Does bedside report promote accountability and sense of ownership in your practice?	67%	33%	0%	0%	0%
Does bedside report provide peer-to-peer learning opportunities?	67%	33%	0%	0%	0%
Do you think standardized bedside report tools increase length of report time?	13%	40%	27%	20%	0%
Do you believe bedside report promotes patient safety?	80%	20%	0%	0%	0%
Does standardized report increase efficiency and communication between nurses?	60%	34%	6%	0%	0%
Do you feel adequate education was provided to facilitate bedside report?	53%	40%	7%	0%	0%

^aSource: Neurosurgical ICU Unit Based Council.

from other ICUs who were pulled to work a shift in the neurosurgical ICU. Often when neurosurgical ICU nurses were pulled to other units, they returned the courtesy of giving a blended bedside report. Multiple ICU nurses remarked that they wished this process was a part of their unit's culture.

FUTURE CONSIDERATIONS

Upon implementation, a standard was created for both the verbal and bedside report components of the blended report. However, the content or adherence to the new standards was not audited, only the completion of both verbal and bedside portions was audited. This would be an interesting area for

future study. To further investigate whether a true unit culture change occurred, it would be valuable to study if new nurses who were not present for the initial blended report education comply with both participation and content of report.

Time efficiency was a concern for nurses, as previously stated it was the number 1 barrier to blended bedside report implementation. The time it took for nurses to give traditional report then at the 3-month mark was measured, but this time was not measured 1 year after the implementation of blended bedside report. This measurement would have been a valuable factor to determine the maintenance of this practice. Any evidence gained would be useful in potentially revisiting the process to streamline its efficiency.

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