

How reliable is your bedside shift report?

A large healthcare system shares its model for success.

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AS OF September 30, 2018, CHSPSC, LLC, and its affiliates and subsidiaries (CHS) had reduced serious safety events by 86% through the use of high-reliability principles. The steps taken to achieve this reduction, including implementing tools and behaviors and taking a structured approach to cause analysis, may be one of the largest efforts taken by a healthcare organization to ensure safer care and to protect thousands of patients from avoidable harm. Combining the bedside shift report (BSR) with a patient safety assessment checklist helped make this initiative a success.



The journey begins

As of December 31, 2018, CHSPSC, LLC, along with CHS consists of 113 hospitals in 20 states; the organization also includes ambulatory care centers, urgent care centers, and physician clinics. In 2012, CHS developed a component Patient Safety Organization (CHS PSO, LLC – AHRQ, PO122) to improve the safety and quality of patient care and embarked on a journey to achieve zero patient harm events by becoming a high-reliability

organization (HRO). By studying the origin of patient safety events and understanding the level of harm they caused, the CHS executive team established safety as one of the organization's core values. CHS partnered with HPI Press Ganey to deploy proven leadership methods and human-error prevention behaviors.

The PSO staff—along with a patient safety committee composed of nurses, physicians, and other subject matter experts—developed a safety strategy and continues to support affiliated hospitals' efforts. Hospital leaders practice leadership methods (daily safety huddles, Safety First [making safety the first agenda item in all meetings], and prioritizing top 10 safety issue lists), recruit local physician mentors to educate medical staffs, and implement the safety coach program.

Safety coaches are frontline team members who teach their peers how to use human error prevention tools, such as the S.A.F.E. toolkit. (See *Keeping it safe*.) At the end of 2018, over 1,200 safety coaches were placed across the organization, with 20,000 recorded safety coach observations that were used to correct and reinforce error-prevention behaviors.

BSR and patient safety

CHS has been using the BSR since 2010. Rather than giving shift report outside the patient's room, nurses going on and off shift meet at the patient's bedside to review the care plan and discuss procedure, test, and medication updates. A study by Williams found that the BSR, which is used on many nursing units across the United States, is one of the most important elements of safe patient care.

CHS affiliated hospitals implemented bedside shift report in an SBAR format (**S**ituation, **B**ackground, **A**ssessment, **R**esponse) and put significant effort into adopting a consistent BSR practice. Initial resistance to the BSR—which included concerns about privacy, confidentiality, and time—was consistent with what the literature reported. A thorough review of a complex patient BSR revealed that it didn't take more time than shift report outside of the patient's room; CHS continues to carefully review overtime. These findings were

Keeping it safe

The S.A.F.E. toolkit teaches error-prevention behavior. It was developed with HPI Press Ganey based on a reliability safety culture diagnostic assessment of common causes of past events.

- **Support the team.** We use tools to: Tools are used to leverage the way staff work together, check the accuracy of team members' work or tasks, identify slips and lapses, point out unusual hazards, conduct impromptu consultations, and correct unsafe or at-risk behavior.
- **Ask questions.** When team members practice with a questioning attitude, they know they're empowered to act when something doesn't seem right or doesn't make sense. They verify with an external source or reference before proceeding in the face of uncertainty or when they need to escalate a concern. Issues are addressed using ARCC:
 - Ask a question
 - Request a change
 - Voice a concern
 - Engage the chain-of-command if a concern isn't resolved.
- **Focus on task.** The chance of human error increases when we're rushed, distracted, multi-tasking, or fatigued. Using the STAR (Stop-Think-Act-Review) method before performing a safety-critical task gives team members' brains a chance to catch up with their actions.
- **Effective communication every time.** Communicating effectively and proactively to eliminate errors in communication (such as mistaking words or numbers that sound similar or omitting important information) is the basis for this tool in the toolkit. Staff can reduce the likelihood of information being misunderstood by communicating with phonetic and numeric clarifiers when words and numbers sound alike. Standardizing hand-off communication using SBAR (Situation-Background-Assessment-Recommendation or plan) helps prevent omitting important information during handoffs such as at bedside shift report.

given to chief nursing officers to share with their staff and allay concerns.

The BSR improved the patient experience, but was it keeping patients safe? Could nurses use BSR processes to communicate and assess triggers for preventable, hospital-acquired conditions (HACs) and other potential safety issues?

Patient safety assessment checklist

Reliability science shows that a complex safety-critical work process that's used by multiple people requires a checklist or job aid to promote consistency. The checklist also can serve as an effective barrier to prevent HACs and other patient harm events.

Through an analysis of our patient safety event and outcomes data, CHS nursing leaders determined that adding an assessment and communication checklist to

the BSR would enhance patient safety. The increased focus by all stakeholders on HACs guided the first version of the HAC Addendum checklist. Conditions covered in the assessment included hospital-acquired infections, central line-associated bloodstream infections, catheter-associated urinary tract infections, falls, and pressure injuries. A companion "Guidelines for Use" document was developed to provide further expectations, details, and resources to ensure consistent comprehension and use of the checklist.

Education for using the HAC Addendum was developed with input from a interprofessional group and was placed on the CHS online learning management system, which allows for web-based, self-paced education. Skills labs were recommended for observing the process to ensure that staff were comfortable and could demonstrate competency. In addition, a demonstration video was produced and distributed to nursing staff and used in new graduate nurse orientation.

As the evidence for preventing HACs grew, so did the content of the HAC Addendum. Patient safety issues—safe cardiac telemetry use, care transition measures, family education related to infection prevention, and falls prevention—that emerged nationally or were reported to the organization's PSO were added to the checklist. As the Addendum grew, CHS acknowledged that it was no longer HAC focused but rather patient safety focused; the name was changed to Patient Safety Assessment. (See *Patient Safety Assessment*.) Accordingly, the guidelines for use were updated with each version of the assessment.

To hold nurses accountable for practicing BSR with the Patient Safety Assessment, nursing leaders rounded on patients every day to validate that they were involved in and aware of the BSR, that their communication white boards were updated, and that they understood their plan of care, including any medications ordered and administered. These validation rounds are essential to BSR/Patient Safety Assessment effectiveness.

Nurses share their creative use of the tools on monthly calls among chief nursing officers from the system hospitals. They've suggested laminating the Patient Safety Assessment, attaching it to clipboards, and adding it to patient communication white boards. Patients' perceptions of the BSR/Patient Safety Assessment also are measured. Beginning in the third quarter of 2013, CHS included a Press Ganey custom question for measuring BSR effectiveness by asking patients: "How well did the nurses communicate with you during bedside shift report?" We also study the correlation between a patient's perception of an effective BSR and Nurse Communication and Overall Rating top box results and have found a strong, positive correlation.

By incorporating patient safety assessments into BSRs, CHS affiliated hospitals achieved a 26.5% reduction in

Patient Safety Assessment

The following are to be reviewed each shift at Bedside Shift Report

CAUTI (catheter associated urinary tract Infection)

Day of insertion:

Necessity/Indication for catheter:

- Hourly I & O Stage III or IV Pressure Injury (formerly pressure ulcer)
- Major GI/GU surgery
- Trauma End of life Urinary Obstruction/retention
- Other - explain _____
- Day in if post op patient
- Peri care performed 2 times/day and documented
- Catheter bag emptied at the end of the shift
- Make sure urinary catheter is secure with unobstructed flow
- If necessity/indication not met, notify provider for order to remove

CLABSI (central line associated blood stream infection)

Each Shift:

Necessity/Indication for central line/PICC:

- Drugs with pH less than 5 or greater than 9, greater than 500 mOsm/L
 - Vesicants/Irritants
 - CVP measurement
 - Parenteral Nutrition (PN)
 - Per medication packaging label
 - Chemotherapy/Bone Marrow Transplant
 - Plasmapheresis/Leukopheresis
 - If necessity/indication not met notify provider to consider alternatives (PIV or Midline)
 - Daily CHG bath (ICU Patient) Time Completed _____
 - Daily CHG bath (MedSurg Patient*) Time Completed _____
 - Central line dressing – dry, intact and change date documented (Transparent 5-7 days) (Gauze 5 days)
 - CHG dressing applied. If no, state reason? _____
 - IV tubing set changed after 72 hours, tubing dated _____
 - All lines traced from tubing to insertion site
- *Please refer to Guidelines Document

DVT

- Protocol reviewed and followed
- Appropriate anti DVT equipment (SCD or TEDS) in place and functioning properly

Telemetry Safety

- Validate channel/telemetry box is correct. Box # _____
- Check pads and batteries
- "Any alarms or notifications" by telemetry handoff?
- Alarms are on and activated
- Candidate for Nurse Driven Protocol Removal YES NO

MEWS (Modified Early Warning Score)

Current: _____ Previous (trended) score: _____

C Difficile

If patient tested positive or highly suspected, place patient on Contact Precautions

Presentation through 1st 3 midnights

Is the patient having loose or liquid stools?

Obtain an order for C. diff. stool culture

After 3 midnights

- Check with physician
- Order for C Difficile testing by physician if at least two signs or symptoms:
- Diarrhea Increasing WBC Fever Loss of appetite
- Nausea Abdominal pain/tenderness

Falls

- Morse risk assessment reviewed /verified _____ (score)

If at risk for falls, verify falls preventions in place:

- Safety Watch Initiated Yes No
- If yes, Rounding every** 30 min 15 min
- If no, Why was Safety Watch not initiated?** _____

- Adequate room lighting/night light
- Bed/chair alarm activated
- Bed in lowest position, locked, side rails x3
- Bedside floor mats when in bed for patients at risk for injury
- Arms reach attendance in restroom/BSC
- Fall risk indicator on armband, door, socks
- Non-slip footwear while ambulating
- Patient/family education and reinforcement "Call Don't Fall"
- Sensory aids/Call Light in reach and room free of clutter

Pressure Injury (formerly pressure ulcer)

- Braden Scale addressed and verified (documented)
 - Verified turned and repositioned 2 hours unless contraindicated
 - Pressure injury (ulcer) protocol if indicated
 - Wound Vac
 - Look under tubes and devices
- Actions taken if Braden score less than 16:**
- Nutrition consult
 - Wound Consult
 - Pressure reducing surfaces

Post Op

- Wound approximated, clean and intact (observe site if indicated)
- Drainage
- Dressing C/D/I

MRSA/MDRO – Contact Precautions

- Signage posted
- Hand hygiene practiced
- Single room if available
- PPE donned and secured prior to room entry
- Dedicated items (BP cuff, stethoscope etc)
- Check report on lab results (if indicated)
- Family and patient education documented in teaching record

Help Prevent Infections Brochure

- Reviewed with Patient
- Reviewed with Family
- Reviewed with Visitors

Prevent Readmissions

- Patient/Family knowledge/ teach back for transition to new level of care
- Respiratory toilet (cough, deep breath, incentive spirometry)
- Aspiration precautions (if indicated)
- Post Discharge visit scheduled, if ordered and has transportation.
- Complete TOC Nursing Discharge Summary Checklist

C Diff Cont

Initiate C Difficile Bundle if positive testing to include

- Soap and H₂O hand wash
- Gown, gloves (each time you enter the room), signage
- Educate patients/families
- Pharmacy involvement/antibiotic stewardship
- Status of room cleaning discussed at unit huddle

CHS Sample Assessment Tool

Reliability science shows that a complex safety-critical work process requires a checklist or job aid to promote consistency.

hospital-acquired infections in 2018 compared to 2017.

Content contained in the Patient Safety Assessment is dynamic, and CHS continues to evaluate it for evidence and trends to be added or removed. The HRO process and tools and leadership support have been instrumental in this successful patient safety initiative.

HRO success

The checklist created to accompany the BSR enables a consistent and thorough assessment of patient needs and concerns, helps nurses assess multiple safety and quality triggers, and ensures patients and their families are prepared for care during and after hospitalization. Chief nursing officers and clinical nurses regularly review and evaluate the assessment tool and make revisions as needed, and its effective use is part of the nursing staff competency assessment. Because the deployment of the Patient Safety Assessment tool was so successful, CHS continues to initiate implementation of other clinical tools based on high reliability principles. ★

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