Investigating Bedside Nursing Report: A Synthesis of the Literature

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Nursing report is an essential part of clinical practice. Patient handoff is accomplished multiple times per day. A great deal of information may be lost during this process, yet there is little certainty about what constitutes best practice (Riesenberg, Leitzsch, & Cunningham, 2010). Current handoff practices include written, audio-taped, face-to-face in a private setting, verbal at the bedside, group reports, and varying hybrids of all of the above methods. Of these practices, verbal report at the bedside is cited in the literature as having many benefits in patient and nurse satisfaction (Anderson & Mangino, 2006; Athwal, Fields, & Wagnell, 2009; Cahill, 1998; Caruso, 2007; Chaboyer et al., 2009; Federwisch, 2007; Howell, 1994; Kelly, 2005; Laws & Amato, 2010; Searson, 2000; Timonen & Sihvonen, 2000; Trossman, 2009). Furthermore, patient-centered care is a concept that has grown in popularity in recent years (Frampton & Guastello, 2010; Rutherford, Lee, & Greiner, 2004). Under these considerations, members of the Medical-Surgical Research Utilization Team (MSRUT) at West Virginia University Hospitals (Morgantown, WV) were intrigued by the possibilities of bedside reporting. This interest prompted a project to review and synthesize the related literature. Synthesis of the literature will form the basis for a change in practice for the nursing reporting process in this hospital system.

Search Strategy

A systematic review of the literature was completed to investigate advantages and drawbacks of bedside nursing report. Qualitative evidence indicated several benefits, but quantitative evidence was not generalizable.

Synthesis of the Literature

The MSRUT identified 42 articles for review and members performed critiques of the articles as Step 3 of the Rosswurm-Larrabee (1999) model for evidence-based practice change. Similar to the systematic literature review of nursing handoffs by Riesenberg and colleagues (2010), the majority of publications in this area were fairly recent and surprisingly little has been published.

Acknowledgments: The authors wish to express their appreciation to the following Medical Surgical Research Team Members for their participation in the literature review process: Christine Daniels, MBA, BSN, RN, NE-BC; Samantha Richards, MSN, MBA, RN; Holly Mattingly, MBA, BSN, RN; Sharon Tykka, BSN, RN; Ella Grimm, BSN; Nancy Stelzer, MSN, RN, NE-BC; Rhonda Hamilton, BSN, RN; Katy Hall, BSN, RN, ONC; Traci Ashcraft, BSN, RN-BC; and Susan Heiskell, MSN, RN-BC.
Of the 12 articles that met inclusion criteria, only four contained quantified data concerning changes in patient satisfaction as a result of moving report to the bedside (Anderson & Mangino 2006; Howell, 1994; Kelly, 2005; Timonen & Sihvonen, 2000). The types of data presented in each article are summarized in Table 1. With the exception of Timonen and Sihvonen (2000), no researchers had a sample size greater than 28 nurses or 20 patients, attempted to determine if their results were statistically significant, or provided information on the validity of the survey instruments utilized. Additionally, the Timonen and Sihvonen study was conducted only after a bedside report (that occurred only in the afternoon) had already been implemented for an unspecified amount of time. The study primarily investigated ways to improve bedside report rather than compare it to any other reporting method. However, with a sample of 118 nurses and 74 patients on four abdominal surgical units and four orthopedic surgical units, 79% of patients (n not specifically reported for this question) and 89% of nurses (n not specifically reported for this question) wanted bedside reporting to continue. Privacy was noted as a concern as 29% (n=51) of patients were disturbed by the presence of another patient in the room while the nursing staff was conducting bedside report.

With a sample size of 20 for both nursing and patient questionnaires at an acute care unit for older adults, Howell (1994) found 90% (n=20) of nurses believed maintaining privacy

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<td>Timonen &amp; Sihvonen, 2000</td>
<td>118 nurses, 74 patients</td>
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<td>Trossman, 2009</td>
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X = no data reported
* Survey’s wording does not specify if overtime is unchanged or increased.
was a problem during bedside report. Eighty-five percent (n=20) of nurses indicated additional information needed to be provided away from the bedside either always or some of the time. Eight of the 20 nurses preferred bedside reporting over report at the nurses’ station, while seven had no preference. The patients’ survey unfortunately only asked about privacy issues, finding 2 of 20 patients were concerned about privacy during the report. This facility transitioned from using a traditional report at the nurses’ station to performing part of the report at the bedside and exchanging potentially distressing or sensitive information in private.

In fact, of the 12 articles, eight described part of the report either occurring in private or the nurse reviewing a written report along with the bedside report (see Table 1). Details of the bedside report process were not reported in three of the other four articles (Cahill, 1998; Kelly, 2005; Timonen & Sihvonen, 2000). Consensus seemed to indicate patients did not want to hear some information repeated multiple times per day, either because they tired of the redundancy or they became depressed or anxious from repeatedly hearing about their health situations (Cahill, 1998; Caruso, 2007).

Kelly (2005) surveyed nurses and patients at a 12-bed rehabilitation unit for older adults within a 142-bed community hospital. Report originally occurred in the nurses’ office. After changing to a bedside report, 11 of the 18 nurses indicated they were more informed about the patients’ conditions and also perceived patients were more involved in their care. A patient survey found 8 of 10 also perceived more involvement in their care. More informed and involved patients was a reoccurring finding with bedside report. Reported advantages and disadvantages for patients and nurses are summarized in Table 2.

Anderson and Mangino (2006) surveyed staff and patients on a 32-bed general surgical unit before and after implementing a bedside report. Unfortunately, no sample size was given for either nurses or patients, and no information was given about how report was performed before this process change. For the bedside report, nurses first reviewed the patient Kardex™ and then followed a report guidelines tool. Among licensed staff, survey results indicated bedside report prompted increased accountability, and caused improvements in passing information, relationships between shifts, accuracy of report, and the amount of pertinent information conveyed. The patient survey found improvements in patient satisfaction in regard to being kept informed, how well staff worked together to care for them, and the perception of staff effort to keep patients informed and involved. No attempt apparently was made to determine if any results were statistically significant. Additionally, a decrease in overtime was noted of over 100 hours in the first two pay periods after implementation and again over the next two pay periods.

Three additional articles contained quantified data concerning nursing satisfaction with bedside report (Chaboyer et al., 2009; Laws & Amato, 2010; Searson, 2000). Searson (2000) reported on the change from a traditional office-based handoff to a bedside handoff on a five-bed, 13-nurse coronary care unit. Initially, part of the report was performed at the nurses’ station to spare the patients from technical jargon. However, this led to nurses returning to the traditional format; thus the decision was made to perform the entire report at the bedside. Six of 10 nurses perceived patients were better informed. Eight of 10 perceived patients were more involved in their care. Five of 10 indicated communication and rapport were better with the patient, while 5 of 10 thought there was no change. Ten patients also were interviewed for their opinions of bedside report. All “thought it was a good idea” (p. 297).

Chaboyer and colleagues (2009) reported results of a change from verbal report in an office to report at the bedside on two medical units and a stroke rehabilitation unit with 74 full-time equivalent nursing staff. The bedside report consisted of an introduction, reason for admission, history, tests and treatments, plan of care, discharge information, answer-
ing of patient questions, safety scan, assessment, and review of medication record. Sensitive information usually was discussed outside the patient’s room or written on the report handoff sheet. A survey of 27 nurses indicated 44% (n=12) agreed both patient safety and the discharge planning process had improved; an unreported number of nurses expressed the perception teamwork improved. An unspecified number of patients also were interviewed concerning their feelings about bedside report. They perceived bedside report as “overwhelmingly positive” (p. 139), but no additional information was given.

Laws and Amato (2010) reported outcomes when moving from a taped report to a bedside report on a stroke rehabilitation unit. Neither survey sample size nor information about the size of the project was given. Nurses used a standardized reporting tool developed for the bedside report but discussed sensitive information away from the bedside. A post-implementation survey found nurses believed bedside report may violate confidentiality, but improves safety, gives patients more opportunity to discuss individual plans of care, takes the same amount of time, reassures patients that the staff is working as a team, and improves accountability. No difference was found in the reporting time based on nurse perceptions. No information was given about how bedside report was received by patients.

Three additional researchers have reported on bedside report without quantifying changes in patient or nursing satisfaction (Athwal et al., 2009; Cahill, 1998; Caruso, 2007). Cahill (1998) conducted 10 patient interviews concerning bedside report and found four patients believed the medical jargon excluded them from the report, while one patient found the jargon reassuring because it reflected skill on the part of the nurses. One patient found the repetition tiring. Another believed patient involvement was an important safety net in preventing inaccuracies or omissions in report. An overabundance of communicated data in report caused anxiety in one patient, while not hearing some information passed from one nurse to another led to feelings of insecurity in another. In this article, no details were given about how the bedside report was performed, or if it was a new or longstanding practice.

In switching from face-to-face report in a conference room, Caruso (2007) found an unidentified number of patients were frustrated with the repetitive nature of bedside reports. This led to only part of the report being performed at the bedside. One patient reported feeling safer because of participation in bedside report. One patient said, “I never knew nurses were so professional and organized” (p. 21). This study occurred on a 36-bed medical-surgical-cardiology unit. A decrease in overtime by an unspecified amount also was reported.

A decrease in report time, nurse overtime, and patient falls was found by Athwal and co-authors (2009) after unit staff changed from a verbal report in a conference room to a combination of a detailed one-page written report and a bedside report on a 34-bed progressive care unit employing 55 nurses. The report time decreased from approximately 40 minutes to 10 minutes, and savings of $8,000 were incurred in 2 months due to a reduction in overtime. Patient falls between 7:00 a.m. and 7:30 p.m. decreased from eight in the 6-month pre-implementation period to one in the 6-month post-implementation period. This was the only study to report on falls with respect to changing to a bedside report. However, the decrease in falls may not be generalizable as this facility previously had not used a taped report; thus more time at shift change would have been spent away from the patient than may be the case at other organizations.

Two articles also reported on the experiences of organizations with bedside nursing report (Federwisch, 2007; Trossman, 2009). Federwisch (2007) indicated the implementation of a bedside report in the SBAR format (situation, background, assessment, recommendations) at Catholic Healthcare West hospitals led to a decrease in the time between coming on shift and seeing the first patient from 30-60 minutes to only 11 minutes. One nurse commented, “…had the nurses been doing shift report the traditional way away from the patient, the result could have been tragic” (p. 14). A hospital director also commented, “Our patients are not being left alone for a long period of time anymore” (p. 14).

Two tools were developed for changing to bedside report at a pediatric hospital (Trossman, 2009). A one-page paper provided nurses with census information, patient acuity, and potential problems, such as patients who had difficulty maintaining intravenous lines. A second paper guided nurses through the bedside report, including performance of a head-to-toe assessment and provision of information on tests and procedures, patient teaching, the care plan, and patient goals. According to managers, informal and formal surveys indicated bedside report improved patient safety, increased patient satisfaction, helped in mentoring new nurses, and improved teamwork. However, neither quantitative data nor representative quotations from nurses concerning their experiences were included in this article.

Limitations

As indicated in Table 1, of the 12 articles included in this review, sample size was not identified in six (Anderson & Mangino, 2006; Athwal et al., 2009; Caruso, 2007; Federwisch, 2007; Laws & Amato, 2010; Trossman, 2009). Only five of the remaining six articles attempted to quantify any data (Chaboyer et al., 2009; Howell, 1994; Kelly, 2005; Searson, 2000; Timonen & Sihvonen, 2000). Excepting the article by Timonen and Sihvonen (2000), the largest sample size was 27. Thus, although the published literature is highly positive about bedside report, findings are not generalizable.

Each study primarily focused on different potential benefits of bedside report. Consequently, although many benefits are reported (see Table 2), little reproduction of results has occurred. Further, specific details
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Objectives

This continuing nursing educational (CNE) activity is designed for nurses and other health care professionals who are interested in bedside nursing reporting. After studying the information presented in this article, the nurse will be able to:
1. Explain patient advantages and disadvantages of bedside nursing report.
2. Describe nurse advantages and disadvantages of bedside nursing report.
3. Discuss implications for practice and research of a systematic literature review investigating the advantages and disadvantages of bedside nursing report.

Note: The authors, editor, and education director reported no actual or potential conflict of interest in relation to this continuing nursing education article.

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about how report was given before and after implementation of this process change often were not given (Cahill, 1998; Kelly, 2005; Timonen & Sihvonen, 2000).

Finally, other facilities may have had negative findings that are unpublished. Successful implementation of bedside report requires a substantial change in how experienced nurses give and receive report. Some health care leaders may identify unsuccessful implementation of bedside report as a personal failure as opposed to an inherent problem with the process of bedside report, and choose not to report results.

Implications for Practice and Research

The positive findings of the published studies suggest bedside nursing report may lead to improvements in patient outcomes as well as patient and nursing satisfaction. The published evidence is highly anecdotal in nature, but the risks of this practice change are relatively low. In light of the available evidence, health care leaders considering this practice change may choose to evaluate a hybrid reporting process, with part performed in private and part performed at the bedside.

At this time, more research is needed. Leaders of organizations that implement bedside report should consider collecting data before and after this practice change. Ideally, data should be collected from patients and nurses with adequate sampling sizes and quantitative results. Additional comparative data may be collected related to overtime, patient falls, medical errors, delays in discharges, and possible delays in treatments. Finally, a detailed description of the reporting process before and after the practice change should be included in any publication.

Conclusion

The nursing shift change report is an essential part of nursing practice. However, little research has been conducted to compare the benefits and disadvantages of various shift report methods. While each article reviewed for this synthesis was highly positive concerning nursing bedside report, all had either small sample sizes where statistical significance had not been determined or provided only qualitative support. Although quantitative evidence is lacking at this time, the risks of implementing bedside report are low, and there appear to be many potential benefits for patient outcomes as well as patient and nursing satisfaction.

The literature to date indicates organizations are finding the most feasible type of report is a combination of bedside report with either a private nurse-to-nurse report or written report to convey sensitive information. More research with adequate sample sizes and determination of statistical significance is needed. Additionally, patient health outcomes associated with bedside nurse report should be investigated to identify best practice.

REFERENCES


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**ADDITIONAL READING**