Implementing and Sustaining Bedside Shift Report for Quality Patient-Centered Care

Sherry Becker, MSN-Ed, RN-BC, CWOCN; Mary Hagle, PhD, RN-BC, FAAN; Andra Amrhein, BSN, RN; Jeffrey Bispo, MSN, RN, CNL; Sarah Hopkins, MSN, RN, CNL; Mary Kogelmann, BSN, RN; Elizabeth Porras, BSN, RN; Melissa M. Smith, BSN, RN

ABSTRACT

Background: Two evidence-based practice projects and an innovative model provided best evidence and a framework for the implementation and sustainment of a bedside shift report (BSR) quality improvement project.

Problem: Without a standardized BSR process, there was a lack of Veteran involvement in care planning decisions and nurse dissatisfaction related to missed communication of pertinent patient information.

Approach: Facilitators and barriers were identified and addressed during planning. Key elements of BSR were incorporated. After approval by shared governance, unit-based champions and leaders supported the change. Implementation began every 2 weeks on a different unit.

Outcomes: Implementation was completed in 4 months for 11 units. After 15 months, there was consistent BSR on 82% of the units and improved patient satisfaction with nurses taking time to listen.

Conclusions: Best evidence, unit-based champions, leadership support, project coordinators, and persistence are critical to implementing and sustaining practice change.

Keywords: bedside shift report, evidence-based practice, nursing, patient handoff, patient satisfaction, patient-centered care

Traditionally, nurses have given shift report to incoming nurses in areas away from the bedside and in a manner excluding the patient. Without being in the presence of the patient, key information about the plan of care may be missed.[1] One solution to improve this situation is bedside shift report (BSR), a face-to-face method in which the incoming nurse is introduced, the plan of care is discussed, patients' questions are answered, and their input is sought.[2,3] Additionally, BSR may promote patient engagement in shared decision-making for their care.[1,4] Published research provides patients' perspectives about their involvement in BSR and their interest in participating.[3,5-7] A recent study revealed that BSR reduces patients' anxiety during hospitalization.[8] Best evidence demonstrates that patients' participation during BSR improves care quality and patient satisfaction.[1,4,9,10]

At 1 midwestern Federal medical center, newly licensed nurses were interested in ensuring the practice and standardization of BSR on all units. Involving the Veteran in BSR reflects our relationship-based care nursing practice model: the relationship between Veteran and nurse.[11] Several hospitalized Veterans (n = 16) were interviewed in 2017 (preimplementation) to understand their perceptions of BSR. Although less than half (43%) were familiar with BSR, most Veterans (75%) wanted to be involved and felt BSR was beneficial to their care. Positive comments included, "I feel as if everyone [the

Author Affiliation: *Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin.*

Grateful appreciation is extended to the Leadership Team and Bedside Shift Report Champions for their contributions and to Mr Chris Saggio for his data support.

The content is the responsibility of the authors alone and does not necessarily reflect the views or policies of the Department of Veterans Affairs or the United States Government.

The authors declare no conflicts of interest.

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's Web site (www.jncqjournal.com).

Correspondence: *Sherry Becker, MSN-Ed, RN-BC, CWOCN, Nursing Education/Research 10AS, Clement J. Zablocki VA Medical Center, 5000 W. National Ave, Milwaukee, WI 53295 (sherry.becker@va.gov).*

Accepted for publication: June 12, 2020

Published ahead of print: August 18, 2020

DOI: 10.1097/NCQ.0000000000000509

healthcare team] is aware of what is happening," and "We're all on the same page." Minimal barriers were identified by most Veterans (84%), which included not wanting to be awakened or interrupted for BSR.

Additionally, 18 clinical staff registered nurses (RNs) were interviewed for their perceptions about benefits and concerns or barriers of BSR. Since nurses are half of the relationship in BSR, it was important to understand their point of view. Several themes emerged from the interviews about the benefits of BSR: Provides a "good clinical picture" and safety assessment, addresses patient concerns/requests, and supports nurse/Veteran engagement. Almost half of the nurses expressed concerns about BSR, including confidentiality, privacy, and potential for agitating the patient. Barriers that nurses identified were having a longer report time, not knowing what the patient knows about their condition, lack of awareness about critical patients on the rest of the unit, general resistance from nurse colleagues, and preference of some nurses for report in the nursing station. Finally, nurses did not want to wake patients who are asleep.

The *I³ Model for Advancing Quality Patient Centered Care*[12] was used for planning. This model provides 3 algorithms to guide the user through the steps for inquiry, improvement, and innovation. Following the inquiry algorithm of this model, 2 evidence-based practice (EBP) projects were completed. In the EBP projects, the literature was synthesized for the (1) outcomes of BSR and (2) facilitators and barriers to its implementation. Next, following the improvement algorithm of the *I³ Model*, the EBP findings were used to guide 1 workgroup in a quality improvement (QI) project to implement BSR using evidence-based interventions and measures to sustain the practice. The purpose of this article is to describe the process and outcomes of implementing and sustaining BSR on 11 inpatient units including 4 acute care medical/surgical units, progressive care/stepdown, intensive care unit (ICU), 1 community home, long-term care, rehabilitation, palliative/hospice care, and spinal cord injury.

PROBLEM

Implementing and sustaining change across multiple units with unique patient populations is challenging. At this medical center, BSR had been implemented in various degrees on some units but not standardized or sustained. Without a standardized BSR, there was a lack of Veteran involvement in plan of care decisions and nurse dissatisfaction related to missed communication of pertinent patient information. Also, it was difficult to sustain the practice when all nurses did not embrace BSR.

APPROACH

Based on the best evidence of BSR outcomes, a practice recommendation for BSR was approved by nursing shared governance. Per the recommendation, all nurses would perform a standardized BSR during patient handoff in which the offgoing nurse reports to the incoming nurse at the patient's bedside using a standardized shift communication tool. Bedside shift report also used language the patient could understand and provided time for questions and answers.

Next, successful project implementation relied on identification of facilitators and barriers. Nurse residents summarized best evidence based on the following PICO (Population-Interest Area-Comparison-Outcome) question: What facilitators and barriers to inpatient bedside reporting can be identified from the literature to create implementation recommendations for nursing staff? Limits included English, adults, and 2010 through 2017, which resulted in 94 articles. All titles were reviewed; 9 met search parameters and were related to the topic. Articles were abstracted onto an evidence table and common themes formed.

Facilitators of BSR

Several facilitators for the practice of BSR and its implementation were found. These included patient preferences for involvement and satisfaction with BSR,[5-7] staff engagement and adherence to expected practice,[13,14] commitment by leaders,[14,15] consistent and active education,[2,14] a standardized BSR tool,[13,16] and audit with feedback.[14,17] These facilitators were addressed while planning and incorporated during implementation.

Thoughtful preparation was critical to success and several steps were completed prior to implementation. Two project coordinators developed a clinical guideline for BSR, which was approved by nursing shared governance. Interested staff nurses from each unit became BSR champions. Monthly meetings were planned in advance of unit schedules to ensure champions' ability to

attend workgroup meetings. An administrative leader agreed to be an executive sponsor of the project.

A patient brochure explaining BSR and the patient's role was developed based on the brochure described by the Agency for Healthcare Research and Quality.[18] The brochure invited the patient and family to participate in BSR and detailed what they could expect during BSR and how they could best participate in their care. The brochure was included in patient folders and was shared with the patient on admission. It was reviewed and revised based on patient feedback through the Patient Education Council (see Supplemental Digital Content Figure 1, available at: http://links.lww.com/JNCQ/A742).

Barriers to BSR

Barriers identified in the literature[2,16,19-24] were targeted during planning. First, inconsistencies in report communication were addressed by developing a standardized BSR process and tool. Nurses had requested a standardized BSR tool to aid consistent transfer of information critical to providing safe care. A tool was developed based on the elements outlined in the literature as necessary to know when assuming care for a patient. The tool was distributed to each unit and feedback shared and incorporated until consensus was achieved. Second, nurses verbalized concerns regarding patient/family involvement and confidentiality. This was addressed through discussion and evidence-based education. Third, nurses also voiced apprehension to the change, which was addressed using change theory. Apprehension about change is a major factor for resistance; change is more easily accepted when the individual is part of the solution and when the purpose for the change is clear. Therefore, to achieve buy-in, the benefits of BSR were widely shared with staff and leaders. Champions and coordinators took time with staff to explain the purpose of the changes. Feedback was sought from staff and leaders during all steps of preparation and implementation.

Leadership support and reinforcement of BSR were needed, as described in the literature.[23] Leaders also may have had varied experiences with BSR. To address this challenge, project coordinators met with nurse leaders one-on-one to explain the process of BSR and the purpose of the improvement, review the evidence for change, share implementation steps, and solicit their backing. Leaders were supported throughout the change and encouraged to reach out for assistance throughout implementation and sustainment.

Implementing and sustaining

Implementation followed several planning meetings with the workgroup. The BSR practice change was to be implemented across all inpatient units in the medical center. A timeline was established, and implementation dates agreed on. The champions and coordinators communicated the implementation plan with unit leaders and nurse educators. The workgroup drafted a BSR tool, which incorporated key elements of patient data found in the literature that were important to discuss during patient handoff. Champions shared the tool with staff and feedback was incorporated, resulting in several formats. The formats all contained the same report elements, but the layout varied depending on how staff typically functioned on a particular unit. Some unit staff preferred a full page (see Supplemental Digital Content Figure 2, available at: http://links.lww.com/JNCQ/A743), while other unit staff liked a condensed version with 2 tools per page. The long-term care unit rounded with the computer on wheels and used the tool as a guide instead of the paper version. For this unit, the writing space was eliminated, and a smaller version was kept on top of the computer on wheels for easy reference. Additionally, a pocket card was created for those who liked to hang the guide on their badge.

Education was developed for RNs and licensed practical nurses (LPNs). Packets were created for each unit, which included a video and slide presentation, the BSR tool and guideline, patient brochure, and audit tool. Methods for education were customized for each unit by the champion in collaboration with the project coordinators. For example, education was presented at unit meetings and huddles, through video, email, and the internal nursing newsletter.

Implementation began every 2 weeks on a different unit to ensure time for rapid cycle improvement. On each unit, the first 2 weeks were devoted to education and the next 2 weeks were for piloting the change. Champions recruited additional staff members to help perform BSR audits with feedback. The audits occurred every other day on all shifts during the pilot to help track the change; auditing with feedback helps

to identify any gaps in expected practice and reinforce the change. Seeking feedback when performing audits is helpful to identify unforeseen barriers to implementation or sustainability. Unit-specific barriers to using the standardized BSR tool were recognized and addressed by the champions with assistance from the coordinators as necessary. Resistance to change was recognized early on as the overarching barrier for some units, not surprising based on the literature and our early nurse interviews. Education about the relationships between BSR, quality outcomes, and nurse satisfaction was emphasized moving forward. Coordinators met with leaders to reinforce the need for their support of this evidence-based nursing practice and to ensure its success.

Practices essential to an effective BSR identified in the literature were incorporated into the audit. These 5 practices included efficient communication, a standardized BSR tool, time for questions, and use of clear language. Most important, the report needed to occur at the patient's bedside. A goal of 95% achievement was set for each practice. An audit was conducted on each unit pre-BSR implementation and was included with each subsequent audit report. The feedback on weekly audits for 1 unit illustrates the pre-BSR practices and the results for each of the practices over 9 weeks (see Supplemental Digital Content Figure 3, available at: http://links.lww.com/JNCQ/A744). Momentum for BSR was sustained by sharing expectations and audit data with leaders and nursing staff at unit and house-wide shared governance councils. As the unit staff maintained their goals, audits decreased in frequency from weekly to monthly, then quarterly. Staff were encouraged to celebrate when they reached their goals.

OUTCOMES

Prior to implementation of a standardized practice, nurses on some units were trying to do shift report at the bedside while nurses on other units continued their usual practice of shift report. One year after implementation, a standardized BSR process had been initiated across 11 units of the medical center, including 4 acute care medical/surgical units, progressive care, ICU, community home program, long-term care, rehabilitation, palliative/hospice care, and spinal cord injury.

All but 2 of the 11 units submitted audit data a majority of the time over the 15 months of implementing and sustaining BSR. One unit, progressive care, has a new champion and audits will be more regular. The other unit, the community home program, recently began submitting data after leadership changes were finalized. The community home program is a neighborhood of 3 homes for 20 Veterans needing minimal nursing care and 9 Veterans needing transitional care while they prepare for residency in the community.

Focusing on 1 of the BSR practices at 15 months after implementation, "Report at the bedside," a majority of units were at goal and 2 were near goal (Table). Despite the differences in types of units and patient populations, the key factors to successful implementation of BSR were similar across the facility. Strong champion involvement and leadership support were fundamental to supporting implementation and sustaining the practice change from early on. Several units started off well, but then lost momentum. After 6 months, only 3 units were at goal for "Report at the bedside." At that point, BSR was declared an expected practice by nursing shared governance, supported by the nurse executive, and incorporated into the nursing strategic plan. BSR audit data were reported monthly to the nurse executive council to hold units accountable. In addition to the data, nurses' observations and close call safety catches were shared. Several units had a challenging beginning and required a second implementation "jump start" before the practice was successful. With the jump start, the units recruited new champions to replace those who had transferred to other units and leaders took a renewed interest.

During BSR audits, nurses recorded many observations related to patient safety. Nursing staff found that Veterans have been able to confirm or correct what the nurse is telling the next shift during BSR. Safety checks occurring during BSR ensure that alarms are activated, lines and drains are connected appropriately, and the environment is free from hazards. One nurse reflected, "With BSR, you can quickly check if indwelling catheter bags have been emptied and pumps have been cleared. You can start each shift with a 'clean slate' and catch potential safety issues or errors before they happen."

"Voice of the Customer" Veteran interviews were conducted on all units 10 months into

Table. Unit Outcomes for Report at Patient's Bedside and Patient Satisfaction With "Nurses Took Time to Listen"[a]

Units	BSR a Majority of the Time	Median Score: 4 Quarters Pre-BSR	Median Score: 5 Quarters Post-BSR	Change
4C med/surg/oncology	Yes	88.5	89.2	0.8%
5C med/surg/cardiac	Yes	90.0	92.0	2.2%
6CN med/surg	Yes	91.6	93.4	2.0%
7C med/75% surgical	Yes	88.6	87.5	– 1.2%
ICU	3/9	No comparable question		
Long-term care	Yes	No comparable question		
Rehabilitation	4/9	No comparable question		
Palliative/hospice care	Yes	No comparable question		
Spinal cord injury unit	4/9	87.2	91.7	5.2%

Abbreviations: BSR, bedside shift report; ICU, intensive care unit.

[a] *Units consistently conducted report at the bedside (meet 95% goal) a majority of the time (≥5 audits out of 9 audits over 15 months). Progressive care/stepdown unit and community home program: no data.*

implementation. Veterans who stated they were familiar with BSR increased from 43% in 2017 (n = 16) to 74% in 2019 (n = 23). Veterans' desire to participate in BSR remained stable over time: 75% in 2017 and 74% in 2019. Positive comments were captured during postimplementation interviews: "I appreciate nurses using language I can understand;" and, "It's nice when the nurses do it [BSR]. Gives me a chance to know what is going on for the day like appointments, labs, changes." Despite verbalizing a desire to participate in BSR, after 1 year only 65% of Veterans in 2019 told interviewers they had participated in BSR. This may reflect the fact that some units do not consistently practice BSR.

One patient satisfaction question may be related to BSR: the nurse listens carefully.[25] This question was examined for all patients discharged from 1 of our 4 medical/surgical units or the spinal cord injury unit. Using a run chart for each unit, our usual practice, patient satisfaction scores were plotted across time for 4 quarters 2 years prior to BSR implementation and for 5 quarters after implementation. A trend line is inserted for each graph, which permits clinicians to draw conclusions about patient satisfaction trends, for example, work on improvement or continue with current practice. For the 5 units, 4 units had positive trend lines while 1 unit remained stable (see Supplemental Digital Content Figure 4, available at: http://links.lww.com/JNCQ/A745).

DISCUSSION

Implementing a practice change, such as BSR, requires the involvement of all nurses: Unit champions to support the change at the bedside, project coordinators to facilitate implementation and reporting, and leaders to support a standardized practice and reinforce the change. One nurse leader at the medical center whose unit has fully adopted BSR regularly rounds on her unit to monitor that shift report occurs at the bedside. Additionally, newly licensed nurses were an enthusiastic group since the start of the BSR initiative in 2017 when 30 RNs in 2 cohorts worked on the 2 EBP projects mentioned earlier. Many of those RNs became champions on their units and are authors of this article. Hagman and associates[20] related a comparable experience that new graduate nurses were "accepting and open to change."

Challenges for implementation included multiple units with unique patient populations, leadership uncertainty, resistance to change on units where BSR was not previously sustained, and staff with varied experiences using BSR. Major concerns of nurses were confidentiality and perceived length of time for report, which dissipated after the first few months of BSR implementation. Confidentiality concerns are reflected in the literature as well with suggestions on how to address these in practice.[3,21]

A unique aspect of this project is the evaluation of BSR after 15 months, which demonstrates

6/11 units consistently having report at the bedside and 3 units close to sustaining the practice. Malfait and associates[26] reported compliance for 12 units to BSR after 1 month ranged from72% to 95%. Although different BSR elements were measured, this study demonstrates the variation in practice after even 1 month. At this medical center, several strategies to sustain BSR were employed. Nursing orientation incorporated BSR as an expected practice as recommended by others.[20] The BSR patient brochure is a permanent part of the admission packet as a shared responsibility between nursing and clerical support. One of the monthly Nursing Grand Rounds featured BSR. The nursing panel was composed of unit champions who discussed their insight and experiences while implementing BSR on their units as well as participating in the EBP and QI projects. Nurses described their motivation, challenges, and outcomes with BSR.

Various outcome measures of BSR have been tracked over weeks to years and reported in the literature at the patient, nurse, and organizational levels.[13,19,27-29] An important outcome at the patient level is patient safety. Similar to reports in the literature,[19,27] safety issues were often caught during BSR. Nurses noted safety issues on their audit forms that were corrected during BSR, such as disconnecting a tube feeding, returning a call light to a patient, and identifying a patient who was deteriorating. Other published patient safety outcomes have included increased perceptions of safety, increased accuracy of information, decreased medication errors, and decreased fall rates.[13,29] In decision-making about our audits, data collection was kept to critical BSR practices as mentioned earlier. Medication errors and fall rates are monitored by each unit and reported to shared governance. However, no significant changes were noted in our medication errors or fall rates that could be attributed solely to BSR.

Improved patient satisfaction using standardized or customized questions has been published.[1,13,14,25,30] As noted earlier, our trend lines for patient satisfaction with "Nurses took time to listen" increased from pre- to post-BSR implementation for 4 units. One published report analyzed this patient satisfaction indicator using a median score for 6 months pre-BSR and 7 months post-BSR with a 7% increase.[25] We used the same methodology and found increases for 4 units of almost 1% to 5%; one unit decreased by 1.2%, which was reflected in its trend line. This unit has been consistent with BSR but has had leadership and staff changes, which may affect patient perceptions. Other published outcomes at the nurse and organizational levels have included improved quality of information at BSR, improved nurse satisfaction, decreased time spent for handoff report, decreased overtime, and increased teamwork.[13,24] These outcomes were not measured during BSR implementation but are being considered for future work for all units.

Nursing implications

There are several aspects of BSR to consider for nursing implications. First, implementing change includes initiation and sustainment, which is an ongoing process. Leadership support, project facilitation, and intentional spread are critical to success and sustainment.[31] Additionally, BSR needs to be patient-centered; nurses need to consider patient preference and their ability and interest in participating at the time. As patients become more involved in BSR, communication improves between the patient and the nurse, opening the door for the patient to identify preventable errors and ultimately improve patient safety.[18] Second, expanding bedside hand-offs outside of acute care, such as the emergency department, and including patients in that handoff is supported in the literature. Last, strategies to enculturate this practice with more speed are needed. After 1 year, there is more work to be done for 100% adoption of BSR practice.

CONCLUSIONS

Bedside shift report implementation takes a concerted effort by nursing staff, project coordinators, and leaders. Auditing processes, measuring outcomes, and disseminating results secure BSR as a standard of practice. Most importantly, and the rationale for conducting BSR, is that it promotes the nurse and their patient to build a relationship. Bedside shift report provides the patient a sense of security. Having the incoming and offgoing RN present allows patient and family questions to be addressed more thoroughly and in a timely manner. Continuity of care leads to trust, accurate information, and increased patient participation. This evidence-based QI initiative has been helpful to keep the Veteran, family, and nursing staff on the "same page".

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