Bedside Report and Hourly Rounding Is Improving Patient and Staff Satisfaction

Lawrence & Memorial Hospital

Team Members:
Jennifer Gale, Alyssa Dyke, Kate Post, Suzanne Eriksen, Suzanne Hatfield, Deborah Moignard, Jill Czernicki, Sharon Sauer, & Diane Lanphear
Project Leaders:
Ellen Crowe & Gail Turner

Bedside Report Goals and Objectives

Goals:

- Safe hand-off
- Patient satisfaction in involvement in care
- Nurse satisfaction

Objectives:

- Utilize evidence based practice to transform care at the bedside
- Identify data driven strategies to be used to measure patient & staff satisfaction as well as the added benefit of cost reduction

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Bedside Report Timeline

	1-Feb	8-Feb	15-Feb	22-Feb	1-Mar	8-Mar	15-Mar	22-Mar	29-Mar	Aril 5	12-Apr	19-Apr	26-Apr	3-May	10-May	17-May	24-May	31-May	7-Jun	14-Jun	21-Jun	28-Jun
5.2	Orient	N/D	D/E	E/N																		
4.1					N/D	D/E	E/N															
4.2								N/D	D/E	E/N												
5.4											N/D	D/E	E/N									
6.2														N/D	D/E	E/N						
5.1																	N/D	D/E	E/N			
LDRP																				N/D	D/E	E/N

Using the Right Approach for Spread

One Unit
One Handoff
One Nurse

Three Week Launch

Nights-Days Week 1 → **Days-Evenings Week 2** → **Evenings-Nights Week 3**

Bedside Reporting Agenda

- Introductions and Goal of Meeting
- Historical Overview of Bedside Report
- Evidenced Based Supportive Data
- L&M PCA Meeting
- Report of L&M Models
  - **4.2**
  - **5.2**
  - **4.1**
- Comparison of Trialed Models
- L&M Model Moving Forward
- Future Plan of Bedside Report Rollout
- Holding the Momentum and Sustaining the Gain

History of Bedside Report

Historically, handovers in hospital settings involved a nurse for the off-going shift reporting to the entire oncoming team of nurses, students, and nursing assistants. Over the last 20 years, reports have changed based on practice and time constraints. The handover process is meant to promote continuity and efficiency while addressing patient calls for inclusion in decision making and increasing safety.

Bedside Report/Hourly Rounding Unit Trials

- Three Bedside Report methodologies containing evidenced based supportive data were trialed on three medical-surgical units for a period of two months.
- Staff representatives from each of the trial units were then brought together to discuss the models and to come to consensus which of the three models would be chosen to roll-out house-wide.
- The staff created a Bedside Reporting Template that would be utilized on all floors for the reporting process and unit to unit transfers.
- A spread methodology was developed.

"The ladder of success is best climbed by stepping on the rungs of opportunity"

-Ayn Rand

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Education

- 1:1 education was done on every shift utilizing educational folders with tools, process, resources and research articles
- The two project leads present to observe and coach staff at shift change x 1 week

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Bedside Report Hand-Off Communication Tool

Item	Handoff Communication Tool
Patient Name and Admission	What brought the patient to the hospital? Diagnosis always. Double person name band verification.
Primary MD	Always
Significant History	Most specific co-morbidities (diabetes), Allergies, Many patients will have a history too long for report. Make this info easily accessible to nurses. These would be entered into electronic database and auto printed onto the PCP
Physical Assessment	State only abnormal findings and relate significant improvement. Resist temptation to highlight your assessment skills. Brief neuro check on any patient with a neuro diagnosis. Weights if ordered
Skin/Braden & Pain assessment	Skin issues if patient has any, list Braden score…PUP tool in place? Patients last pain level and treatment if any.
Fall Status/ Mobility/Lift status	State only if patient is at higher risk for falls, along with the fall risk score. Lift status documented on white board?
Code Status/ Precautions	State any directive or specification, list any precautions
IV , I&O , Dressings	Give ordered fluid and rate. May describe insertion site and gauge Give I&O only if ordered or significant as a nursing measure Describe dressing and any wound care receiving
Labs	State only abnormal values. State normal values only when specifically applicable to diagnosis (e.g. WNL H&H after bleed)
Timed Events	PRN meds, treatments, events
Patient Specific Needs	Any issues not covered in assessment. "Anything else we can do to address your needs"
Changes in Condition	Any new clinical findings or improvements
Consult	New and/or relevant
Current Treatment Plan	Vital – keep it simple (IV fluids and observe/elevate rt leg)
New orders	As appropriate, especially related to new txs or medications the oncoming nurse will need to know, i.e. NPO status
Documentation I&O's, Daily weights	MAR, flow sheet, plan of care, teaching record (IDT), PCP, W-10 updated and current, Rounding sheet completed, I&O's completed every shift, Daily weights documented
Discharge Plans	State none, or give specifics

Bedside Report Undelivered

Pt Name: Age:	Reason for hospitalization:	Plan:
Dr:		
Allergies:		
Admitting Diagnosis:		
EDC:	Wheel out weeks/days	
Gravida: Para:		
Significant History:	Medical & Obstetric History:	ROM, Vaginal bleeding, Twins
EFM:		If intermittent, schedule
IV Site, solution & rate, bag#	Continuous ot intermittent fluid and rate TC:	Date to be changed
Diet:	Bed rest/BRP or commode:	
Activity:		
Skin/Braden:		
Fall status/Mobility/Lift status:		
Precautions:		
Daily weights:		
I&O if ordered:		
Steroids:	When received or dose due:	
Change in condition:	SVE, U/S, Daily weights	
Procedures:	MFM and date:	Urine dips/24 hr urine glucose
Consult:		
Plan of care:	Plan for discharge/delivery	

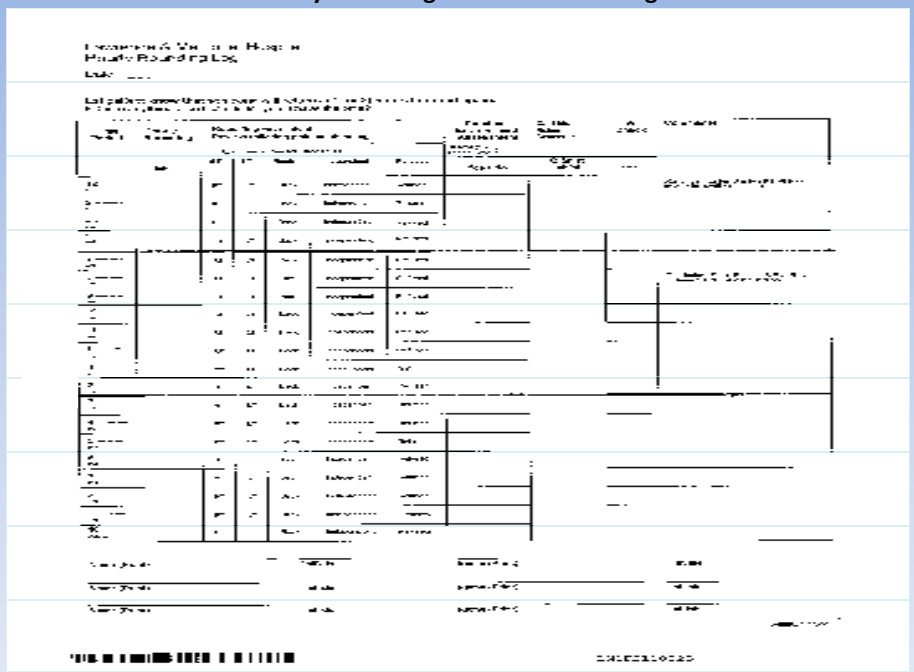
Bedside Report Labor

Pt Name: Age:	
Dr:	Always
Reason for admission:	Prodromal labor, Induction
EDC: Gravida: Para:	Coverage
General & Obstetric History:	Spontaneous labor
Allergies:	GDM, Oligo, LGA etc.
SROM/AROM-GBS status	Always
Dilatation/Effacement and Station:	Color i.e. MSAF, odor
IV site/solution/rate, bag#	+GBS-Treatment, dose & time due
Plan of care:	Previous bolus, to credit
Daily weight:	Pain management
Skin/Braden:	Stadol dose & Time, epidural or birth plan
Fall status/Mobility/Lift status:	
Precautions:	
I&O:	
EFM:	Continuous or intermittent, internal monitors or Amnioinfusion Abnormal tracing
Status of neonate	
Social issues	
Family support	

Bedside Report Postpartum

Pt Name: Age: Dr: Allergies Delivery date, time, route Infant sex Breast or Bottle Gravida: Para: Significant History IV site, solution and rate, bag# Procedures Void or Foley Dressing or incision Diet Pain Labs Daily weight I&O's Skin/Braden Fall Status/Mobility/Lift status Precautions Discharge Plan **Infant** Dr: Breast or Bottle Void Stool **Procedures:** Circumcision Tylenol dose PKU/ CF TCB or Bili Weight PG Protocol Car Seat Test	Reason for hospitalization: Always Always If printed PCP used, info already there expound if d/c today Always Always Always Update for after delivery Medical History If HL and time to d/c Treatments if any and timed events QS Void, address I&O if ordered Pain: time/medication/effect Only abnormal values Original dsg/drainage or telfa VNA/Special F/U Types, Effectiveness, last feed Alterations ie urates Loose/bloody stools Date of Circ/condition If completed Results or time due If > 10% loss LGA/SGA Abnormal values/time of next If applicable and if car seat	Id band with DOB: Social History and plan in private Date to be changed High risk Steri strips or wound care Lab draw due HNV in>24Hr Alteration in stools Doses of Tylenol Given or due Result of serum/next lab draw Pg and feed Available and pt aware of test

Hourly Rounding Documentation Log



Bedside Report/Hourly Rounding Data Collection

Data collection includes the following target measures:

- Patient Satisfaction
- Staff Satisfaction
- Incidental Overtime Usage

Collection dates on each unit were determined by the original date of rollout. The units received data from the following intervals:

- 2 Weeks from go-live date
- 6 Weeks post rollout
- 3 Months post rollout
- 6 Months post rollout

Data is shared with the Bedside Reporting Team and discussed monthly. It is shared with staff through staff meetings, data displays on the units, and through the shared governance structure.

Bedside report/Hourly Rounding Data Collection Dates

Units	Week 2 surveys	Week 6 surveys	3 month surveys	6 month surveys
5.2	March 8th	April 5th	May 17th	August17th
4.1	March 29th	May 17th	June 28th	September28th
4.2	April 19th	May 17th	June 28th	September28th
5.4	May 10th	June 7th	July 19th	October 19th
6.2	May 31st	June 28th	August 9th	November 9th
5.1	July 19th	August 16th	September 27th	December 27th
LDRP	July 12th	August 9th	September 20th	December 20th

Data to be collected:
Patient and employee surveys, and incidental overtime reports

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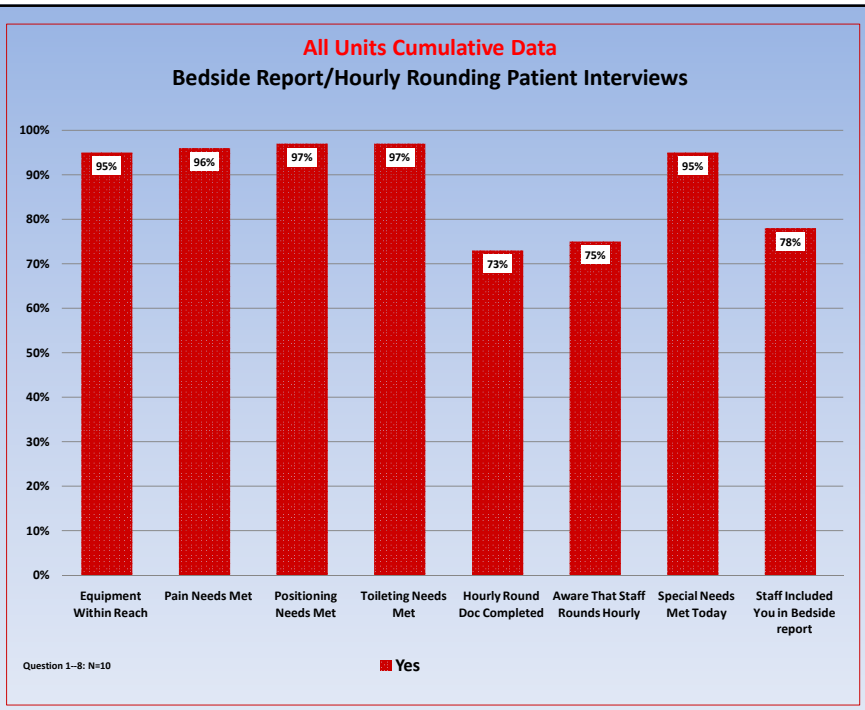
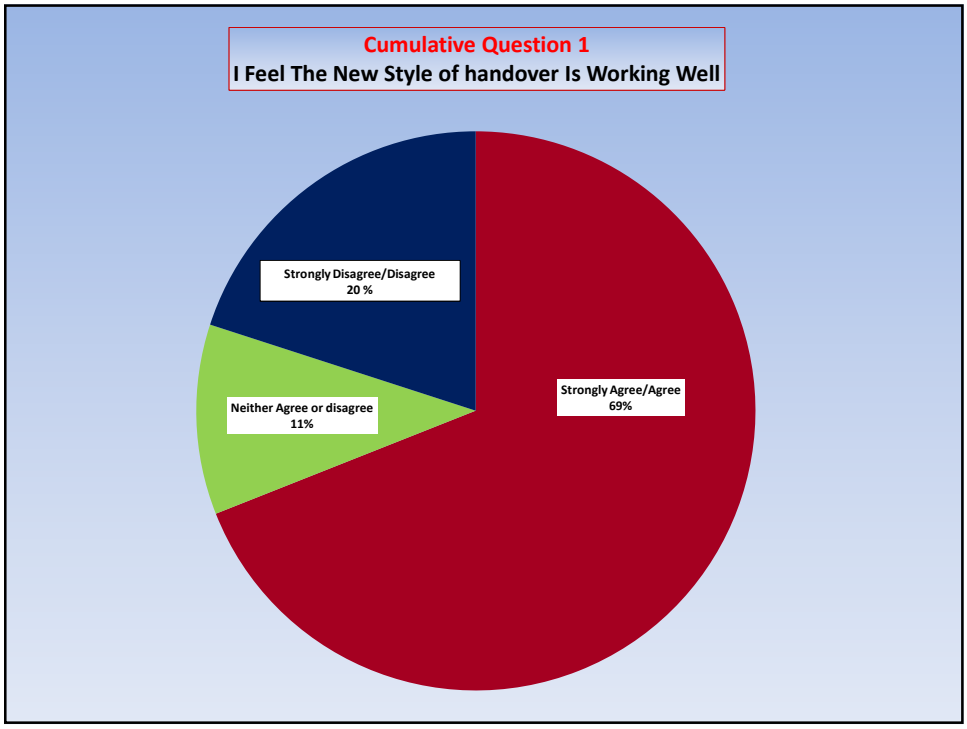
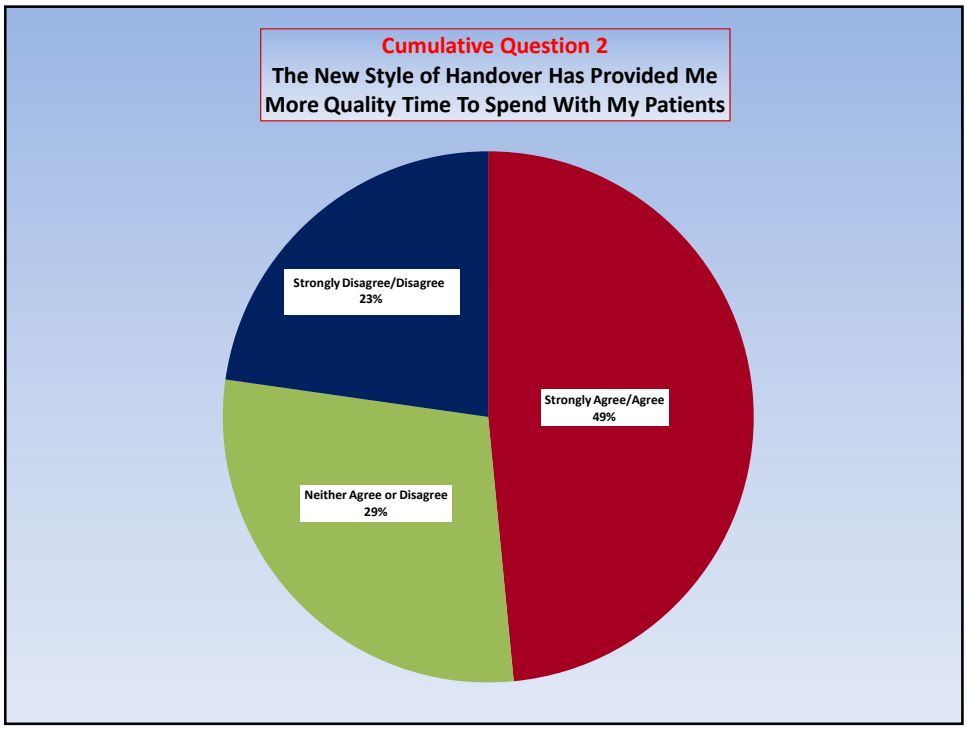
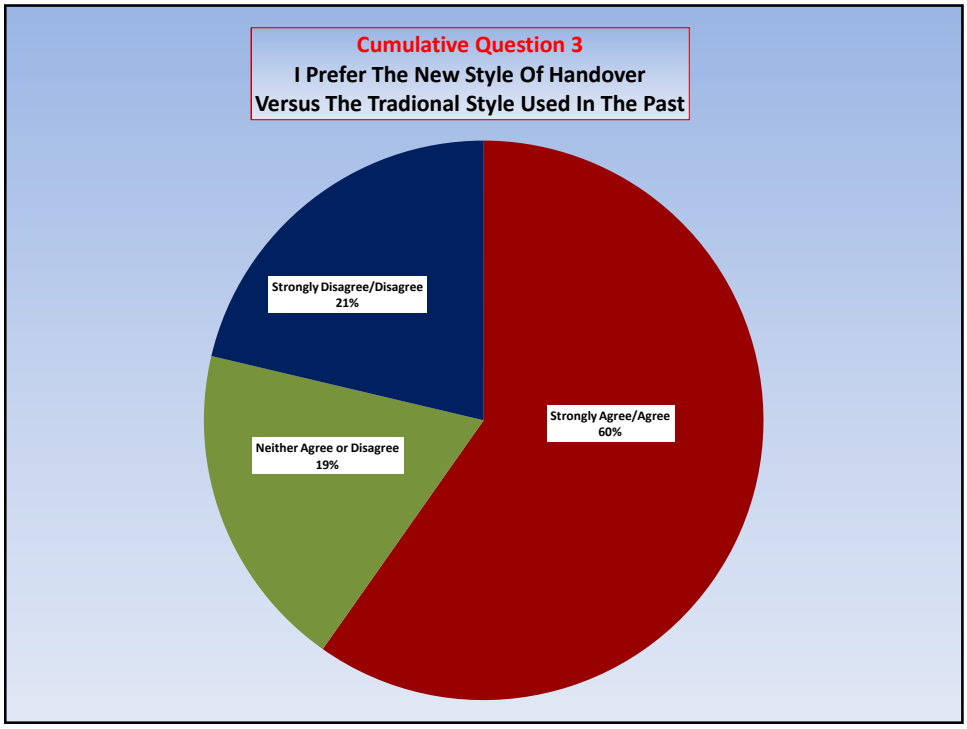
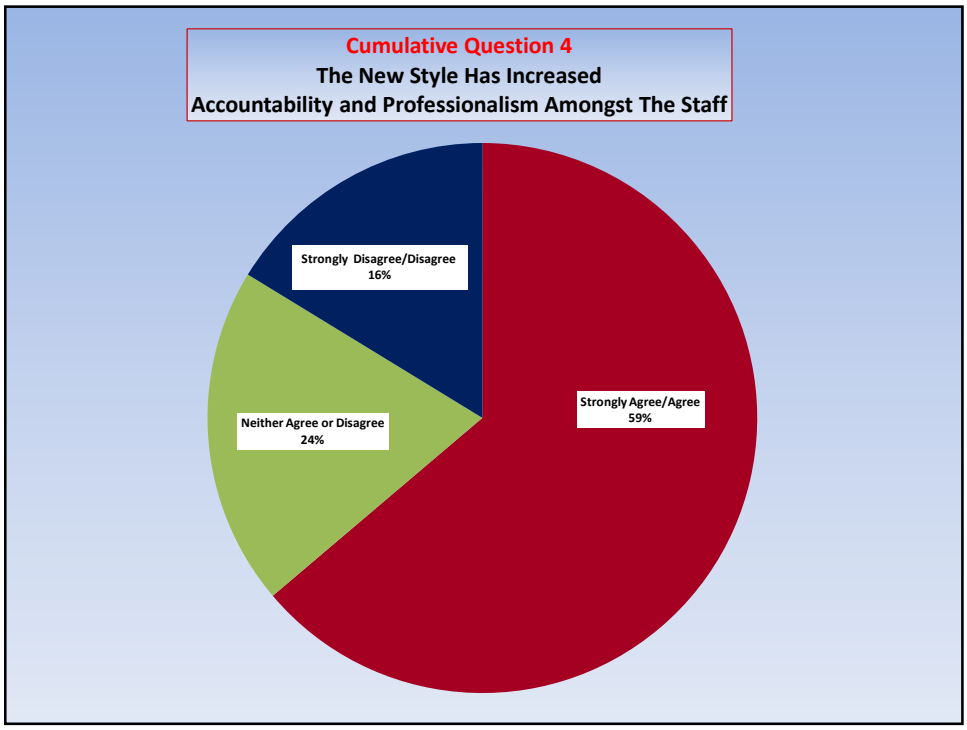



Cumulative Question 1
I Feel The New Style of handover Is Working Well
Strongly Disagree/Disagree
20 %
Neither Agree or disagree
11%
Strongly Agree/Agree
69%


Cumulative Question 2
The New Style of Handover Has Provided Me
More Quality Time To Spend With My Patients
Strongly Disagree/Disagree
23%
Neither Agree or Disagree
29%
Strongly Agree/Agree
49%


Cumulative Question 3
I Prefer The New Style Of Handover
Versus The Tradional Style Used In The Past
Strongly Disagree/Disagree
21%
Strongly Agree/Agree
60%
Neither Agree or Disagree
19%


Cumulative Question 4
The New Style Has Increased
Accountability and Professionalism Amongst The Staff
Strongly Disagree/Disagree
16%
Strongly Agree/Agree
59%
Neither Agree or Disagree
24%

Bedside Report/Hourly Rounding Yearly Cost Savings Projection

- Three units have currently completed six months of data collection which enables us to project the yearly cost savings
- These units are 5.2, 4.1 and 4.2 which were the units that had originally trialed the various models

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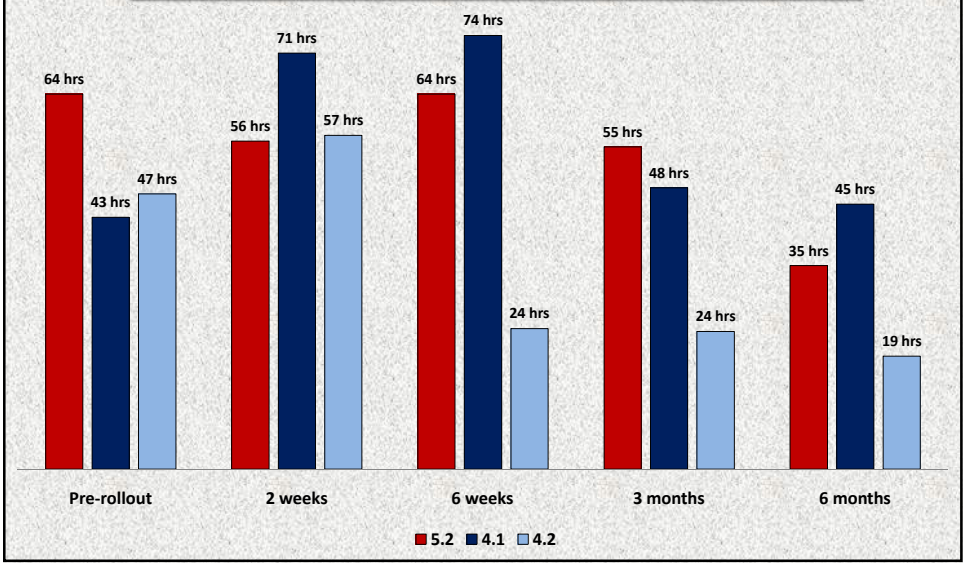
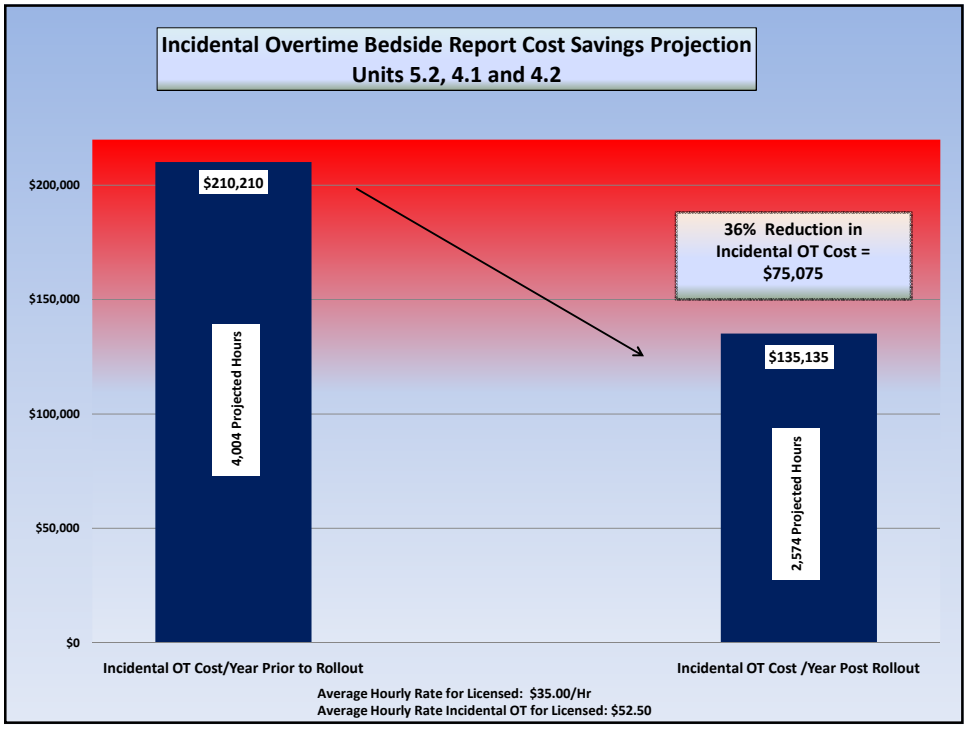
Incidental Overtime Usage Pre and Post Bedside Report Units 5.2, 4.2, 4.1





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