

Patient and Nurse Outcomes of Bedside Nursing Report Implementation

Posted on September 29, 2018

View this essay online:

<https://academic-master.com/assessment-of-patient-and-nurse-outcomes-of-bedside-nursing-report-implementation/>

Introduction

Bedside nursing report is a shift-handoff method in which the outgoing nurse, incoming nurse, and patient review relevant information together at or near the bedside rather than transferring all information away from the patient. The approach is intended to improve continuity, accountability, patient participation, and immediate safety by making the handoff visible and allowing nurses to verify the patient's condition together. Sand-Jecklin and Sherman's 2014 study, *A Quantitative Assessment of Patient and Nurse Outcomes of Bedside Nursing Report Implementation*, remains useful because it examined a real practice change across seven medical-surgical units and followed both patient and nurse outcomes over time. The intervention was not a bedside-only handoff; it used a blended model combining recorded report with bedside exchange. That distinction matters because the study's findings apply most directly to the specific system implemented in the hospital. The results suggest that bedside report can improve patient involvement and some nursing outcomes, but they also show that implementation quality, privacy protection, staff training, and fidelity determine whether the practice actually delivers its intended benefits (Sand-Jecklin & Sherman, 2014).

Study Design and Implementation

The researchers used a quasi-experimental pre- and postimplementation design rather than a randomized trial. Such a design is practical for a hospital-wide workflow change because nurses and patients cannot easily be randomized to completely different handoff systems while normal staffing and unit operations continue. The trade-off is weaker causal inference: changes in falls, satisfaction, or nurse perceptions may partly reflect other events occurring during the same period. Data were collected at baseline, approximately three months after implementation, and again at about thirteen months. Patient surveys were completed by 233 patients at baseline, 157 at three months, and 154 at thirteen months. Family members also completed surveys, although some family data were excluded from comparisons because relatives were not always present during the actual report. Nurse participation was 148 at baseline, 98 at three months, and 54 at thirteen months, a substantial decline that creates possible response bias and means the later respondents were not necessarily the same nurses who completed the earlier surveys.

Implementation itself changed over time. When the first postimplementation results showed inconsistent bedside-report practice and concerns about efficiency, the research team added tip sheets, posters, manager and preceptor observation, one-to-one feedback, and documentation changes. These supports are important because they make the study more realistic: clinical practices rarely become reliable simply because a policy is announced. At the same time, they complicate interpretation because the thirteen-month results reflect both bedside report and the additional coaching and monitoring introduced after the initial rollout. The study therefore evaluates a change process as much as a communication technique. Fidelity also mattered. Some patients reported that bedside report did not occur consistently or consisted mainly of an introduction to the oncoming nurse. If essential communication still happens elsewhere, a nominal bedside-report policy may exist without delivering patient participation or visual safety checks. Successful implementation requires a defined structure, staff education, leadership feedback, and monitoring of whether the intended elements actually occur.

Patient and Nurse Outcomes

Patient satisfaction was already high before the intervention, creating a ceiling effect that limited how much improvement could be detected statistically. Even so, several items directly related to handoff improved over time. Patients became more positive about knowing who their nurse was, being encouraged to participate in care, being included in shift-report discussion, and seeing important information passed from one shift to the next. These findings support one of the central arguments for bedside handoff: the process can make nursing communication visible to the patient instead of treating the patient as the subject of a private conversation conducted elsewhere. Patient participation can also identify errors, clarify priorities, and allow the incoming nurse to hear concerns in the patient's own words. Participation should remain optional and respectful, however. A patient may be tired, distressed, cognitively impaired, or simply prefer that sensitive matters be discussed privately. Bedside report works best when it increases inclusion without assuming that every patient wants the same level of involvement in every conversation.

Nurse outcomes were more mixed and reveal an adaptation period. After implementation, nurses reported stronger accountability and greater patient involvement, consistent with the purpose of bedside report. Some perceptions of efficiency, effectiveness, and stress became less favorable at the three-month point, then moved back toward baseline by thirteen months. Nurses may therefore experience a new handoff method as slower or more cumbersome before they become familiar with the sequence and expectations. Importantly, the perception that report took longer was not matched by a significant rise in nursing overtime. This distinction between perceived effort and measured time is useful for implementation decisions. A workflow can initially feel inefficient while staff are learning it without materially extending the paid workday. Later acceptance may depend less on persuading nurses that the method is inherently better than on giving them practical tools, clear expectations, privacy strategies, and enough experience to integrate the process smoothly into routine care.

Safety, Privacy, and Communication Quality

The study reported a substantial reduction in patient falls occurring around shift change after bedside-report implementation. The finding is clinically plausible because two nurses are briefly present together and can verify mobility status, alarms, bed position, call-light access, intravenous lines, drains, oxygen, and other immediate safety concerns. The quasi-experimental design prevents certainty that bedside report alone caused the decline, but the result supports the value of combining verbal communication with direct observation. The medication-error outcome requires more caution. Sand-Jecklin and Sherman reported that an intervening variable invalidated comparison of medication errors before and after implementation, so the study should not be cited as proof that bedside report reduced medication errors. This distinction is important in research appraisal: an outcome the investigators intended to measure is not automatically a valid result. Evidence is strongest when conclusions follow the data actually supported rather than the benefits readers expected the intervention to produce.

Privacy remains one of the main practical challenges. Bedside handoff can involve diagnoses, behavioral health concerns, substance use, sexual health, safeguarding issues, family conflict, or information a patient has not shared with visitors. Shared rooms create additional risk. Nurses therefore need clear guidance on what can be discussed openly, when visitors should be asked to step out, and when sensitive information should be transferred away from the bedside. Recent qualitative evidence continues to show that both patients and nurses value the partnership and individualized care associated with bedside handover while also identifying confidentiality, time, communication quality, and consistency as important barriers or facilitators (Anshasi & Almayasi, 2024). Standardized structures such as SBAR or a locally validated checklist can reduce omissions, but a checklist should guide rather than replace clinical judgment. The handoff should communicate the information the incoming nurse needs while respecting the patient's preferences and privacy rights.

Study Appraisal and Practice Implications

The study has several strengths. It involved seven real medical-surgical units, used repeated measurement over thirteen months, included patient and nurse perspectives, and examined operational outcomes in addition to satisfaction. The longer follow-up is particularly valuable because nurse perceptions changed between the early and later phases, showing why short implementation evaluations can be misleading. Its limitations are equally important: there was no randomized control group, nurse response rates declined substantially, baseline patient satisfaction was already high, adherence to the bedside process was inconsistent, and the study occurred in one university hospital. Findings from medical-surgical units may not transfer directly to intensive care, pediatrics, psychiatry, maternity, emergency departments, or long-term care, where privacy, family participation, acuity, and patient capacity can differ considerably. Some outcomes were also perceptual rather than direct

measures of communication accuracy. Future evaluation can combine surveys with observed handoff-content audits, interruptions, omissions, escalation events, patient understanding, adverse events, workload, and privacy incidents.

For practice, bedside report should be treated as a structured clinical process rather than a ritual or slogan. Organizations need to define the required content, explain which topics should be discussed privately, train staff, involve patients in designing the process, and monitor fidelity over time. Early inefficiency should prompt coaching and workflow refinement rather than immediate abandonment, while persistent problems should be measured honestly. Educational interventions can improve handoff knowledge and performance, reinforcing the need for deliberate skill development rather than assuming nurses will master a new process automatically (Choi et al., 2024). Outcome monitoring should extend beyond satisfaction to falls, overtime, handoff-related errors, patient understanding, interruptions, workload, and confidentiality. Most importantly, bedside report should serve the patient rather than the policy. A successful handoff is one that communicates essential information accurately, verifies immediate safety, respects privacy, and gives the patient an appropriate opportunity to participate.

Conclusion

Sand-Jecklin and Sherman's study provides useful evidence that a blended bedside nursing report can improve several aspects of patient participation and nursing accountability without significantly increasing overtime, while also being associated with fewer falls around shift change. The findings do not establish that bedside report reduces medication errors because that comparison was invalidated by an intervening variable, and the quasi-experimental design prevents attributing every observed change to the intervention alone. The study's most important lesson is therefore broader than whether bedside report is "better" than another handoff method. Communication quality depends on implementation fidelity, training, privacy protection, structured content, leadership support, and adaptation to the clinical setting. Patients should be invited into the handoff without being forced to disclose sensitive information publicly, and nurses need clear procedures for shared rooms and confidential topics. Bedside reporting can strengthen continuity and patient-centered care when it is implemented as a thoughtful communication system rather than reduced to a required introduction at shift change.

References

- Anshasi, H., & Almayasi, Z. A. (2024). Perceptions of patients and nurses about bedside nursing handover: A qualitative systematic review and meta-synthesis. *Nursing Research and Practice*, 2024, 3208747.
- Choi, J. Y., Byun, M., & Kim, E. J. (2024). Educational interventions for improving nursing shift handovers: A systematic review. *Nurse Education in Practice*, 74, 103846.

Sand-Jecklin, K., & Sherman, J. (2014). A quantitative assessment of patient and nurse outcomes of bedside nursing report implementation. *Journal of Clinical Nursing*, 23(19-20), 2854-2863.

<https://doi.org/10.1111/jocn.12575>

Sherman, J., Sand-Jecklin, K., & Johnson, J. (2013). Investigating bedside report: A synthesis of the literature. *MEDSURG Nursing*, 22(5), 308-312.