Abstract

Communication failures during shift change are a leading cause of sentinel events in the United States. The Joint Commission's National Patient Safety Goals are aimed at advocating precise communication among the healthcare team and high-quality, safe patient care. Nurses are instrumental in the achievement and implementation of the objectives. Nurse to nurse communication is essential to ensure that patient outcomes are achieved. The purpose of this project was to create and implement an evidenced-based policy for bedside shift handoff report. The work of Kurt Lewin guided the project in terms of the process of institutional change. PDSA (Plan-Do-Study-Act) functioned as a continuous quality improvement model to inform the development of the implementation and evaluation plans. The project team development implemented and evaluated the continuous quality improvement plan. The project involved education to standardize the flow and process of the handoff report. It was anticipated that education and implementation of a standard handoff report that provides a discussion of the plan of care with accurate information at the bedside, would promote patient and family involvement. Improved nurse-patient communication embraces meaningful aptitude to improve accurate communication to promote positive social change across the institutional service population.

Keywords: *nursing shift reports, shift report, nursing handoffs, handoffs, adverse events, patient safety, bedside handoff, change of shift report, change-of-shift report, nurse handover, shift handover, medical rounds report, medical grand rounds, and patient and family-centered care.*