Improving Nurse's Documentation in the Emergency Department

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Abstract

The appropriate documentation and effective hand-off communications are essential components for attaining and maintaining the continuity of quality care for patients in the emergency department. Despite global efforts and standards geared towards improving the accuracy and function of documentation, the issue of incomplete documentation and hand-off communication persist in the local emergency department. Incomplete documentation and handoff communications have been regarded as key factors of delayed patient care as well as discontinuation of care in the clinical setting. A detailed study conducted for evaluating the effectiveness and benefits of the Institute Healthcare Improvement SBAR guideline as a checklist on nurses' documentation and hand-off communications was conducted in the local Emergency Department. The pre and post design utilizing the SBAR Assessment tool adapted from Sears, et al. (2014) was used for collecting data from a convenient sample of 30 nurses. Evaluation of the study revealed clinical significance where 96.7% of the participants believed that the SBAR checklist tool positively influenced effective communication between the healthcare team, patients and families creating a culture of safety for both the patient and the nurse. While 50% of participants believed that the checklist reminded them of important information to document and their message was fully received and understood. The findings from the study have positive implications for the clinical setting to assist in cultivating a climate of safety for the patients, nurses, the organization and the community to maintain a positive outcome.

Keywords: SBAR, miscommunication, checklist, structured, standardized tool, incomplete, documentation, hand-off communication, hand-over

Dedication

I would like to dedicate this project to my family for being there with me throughout the two years of hard work. To my husband Marc for your continuous support and guidance. My children Jamarr and Jordin, thank you for being so understanding. And to all my friends, co-workers, and families a big thank you for your continuous support and love.

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Executive Summary

Purpose: The purpose of the project was to evaluate the effectiveness of the IHI SBAR (Situational, Background, Assessment, Recommendation) guideline as a checklist on nurses' documentation and hand-off communications in the Emergency Department.

Background and Significance: Even though documentation of nursing care is a vitally essential part of nursing practice, the documentation of care is often left undone (Kebede, et al, 2015). This problem has gained worldwide recognition owing to the negative impact it has bestowed upon everyone involved. Effective nursing documentation is essential for tracking patients' condition, decision making regarding their needs and to ensure continuity of care.

Methods: A pre- and post-design was used to collect the responses on the use of the IHI SBAR guideline as a checklist for improving documentation and hand-off communications for a period of four weeks. A SBAR Assessment Evaluation Tool was utilized to assess the nurses' perception of the tool. Ethical approval was obtained after which a convenient sample of 30 nurses participated in the study for 4 weeks. Descriptive statistics was performed using the IBM SPSS v25 to calculate the data.

Findings: The study revealed a significant finding in that 96.7% of participant post- intervention believed that good communication exists between the healthcare provider, patients and families**.**

Conclusion: The overall study concluded that utilization of a structured tool, SBAR checklist continued to be a fundamental part for creating a culture of safety for the patients.

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CHAPTER 1: INTRODUCTION

Improving Nurses' Documentation of care in the Emergency Department

The use of the common phrase, "If it was not documented it was not done," demonstrates the clear picture of the significant importance of accurate and adequate documentation for promoting patient safety in nursing care. Nursing documentation originated with Florence Nightingale that had utilized diagrams for charting the cause of death during the Crimean war (Nakate, et al, 2015), today's documentation of patient care can be either written or electronic. Since the birth of documentation, it has evolved and is now recognized as an essential constituent for providing holistic nursing care. Effective documentation assures quality care, conserves time and reduces the risk of errors, facilitates continuity of patient care, promotes communication and collaboration among nurses and other interdisciplinary teams, and is necessary for enabling the team in making informed decisions that yield positive patient outcomes (Nakate, et al, 2015).

Despite global efforts for improving documentation, the issue of incomplete documentation persists and has been identified as key factor in causing delayed patient care and discontinuation of care in the local emergency department. Such mishaps have led to adverse events and unsatisfactory outcomes for all stakeholders involved. Incomplete documentation has caused miscommunication among nurses and led to detrimental errors, higher expenses, readmissions, and below par patient satisfaction (Insteford, et al, 2014). According to Nate et al. (2015), documentation has been essential for promoting safe, ethical and effective nursing practice in the clinical setting and has been essential for expressing a clinical picture of a patient's condition from the lens of the clinician.

The purpose of the project proposal was to implement and evaluate the effectiveness of the structured, standardized SBAR checklist on documentation. This evidence-based

intervention required collaboration, leadership, education, visual cues, environment and resources that facilitate emergency room nurses in the completion of documentation of their patients' care in a timely manner. This intervention has been proven to facilitate the effectiveness of hand-off communications and has promoted continuity of patient care.

Problem Statement

The problem of incomplete documentation among nurses in the emergency department has consequently resulted in delayed care and unsatisfactory outcomes for all parties involved. Such mishaps have impelled nurse leaders to pursue positive alternative strategies for addressing this issue by effectuating positive changes in their working environment. The exploration for solutions has led to the development of the problem statement; for nurses working in the emergency department at a local hospital, does the implementation of the Institute of Health Improvement SBAR guideline as a checklist compared to unstructured hand-off forms help to improve documentation and hand-off communications among the emergency department nurses in 8 weeks?

The structured standardized SBAR guideline intervention was geared towards assisting nurses in prioritizing documentation of relevant patient care in a timely and ethical manner to promote communication, continuity of care, and to help other members of the team in making informed decisions based on the data provided.

Objectives and Aims

Despite initiatives for improving the documentation landscape, several inadequacies lead to unsatisfactory outcomes such as medical errors, miscommunication, and discontinuity of care. Okaisu, et al, (2014), highlighted that in spite the global effort to improve on inadequate

documentation, the issue still exists as nurse leaders attempt to identify barriers and challenges to the problem.

The aim of the project was to bring awareness to the group on a variety of best practice approaches that are currently available to help address this grave issue of incomplete documentation and create an environment of safety to achieve positive outcomes. To achieve such outcomes, the following objectives were executed to:

- Identify factors that contribute to incomplete documentation among nurses.
- Discuss the impact of the problem on the nurses' working environment.
- Review articles on best practices that will address the problem and compare them with the current practice.
- Discuss with the main stakeholders the feasibility of the proposed intervention and to earn their buy-in.
- Educate and train staff on the recommended intervention.
- Implement and evaluate the effectiveness of the planned intervention.

The legal, professional, and financial ramifications of incomplete documentation have created a stressful environment for nurses and all the other stakeholders involved. It is eminently important for nurse leaders to establish a learning environment that will promote ways to solve the related problem and create a culture of safety. Regan, et al, (2016), recommend providing infrastructure, delivering relevant knowledge, resources, and support to staff to promote growth and increased workplace safety.

Significance of the Practice Problem

Even though documentation of nursing care is a vitally essential part of nursing practice, the documentation of care is frequently left undone (Kebede, et al,2015). The problem of

incomplete documentation has gained worldwide recognition based on the negative impact it has bestowed upon everyone involved. International and local bodies have emphasized that documentation has a professional and lego-ethical requirement for ensuring accountability and for assisting in promoting the uptake of evidence-based practice (Nakate, et al, 2015). The problem of incomplete documentation has drawn criticism from nursing professionals and communities, health organizations, and regulatory bodies owing to the severity of incomplete and sub-standardized charting. A study in a children hospital in Uganda found inadequate documentation of nurses' assessments from a recent audit, requiring nurse leaders to take a stance to improve the standard of documentation for achieving patient safety (Okaisu et al. 2014).

According to Nakate, et al, (2015), adequate nursing documentation has been essential to providing quality of care, saving crucial time, and preventing medical errors. The authors have indicated that proper nursing documentation allows for tracking the changes in patient condition, making decisions regarding their needs, and ensuring continuity of care.

Incomplete documentation of care at the local emergency department has contributed to a decrease in the nurse satisfaction scores, as well as a negative impact on the Hospital Consumer Assessment of Healthcare Providers and System scores (HCAHPS). Another issue encountered regarding incomplete documentation in the Emergency Department was the poor transition of care among nurses during shift changes and patient transfers. Okaisu, et al, (2015), described a British study that illustrated how poor documentation caused increase in-hospital and post-discharge deaths. Nurse leaders and clinical educators at the local level has actively sought for best practices that may effectively address these dire issues. The legal ramifications of incomplete documentation that results in patient harm such as medical errors and death may

cause devastating financial and legal matters for the organization, the community, and the staff. External stakeholders such as insurance companies and The Center of Medicaid and Medicare are hesitant and often deny reimbursing the organization for adverse events, medical errors, and readmissions noted as negligence on the part of the organization. The Joint Commission (2018), as a regulatory body, has established partnerships with healthcare organizations for improving the working environment, reducing variations, reducing risk and improving quality.

The problem of incomplete documentation was considered at the micro, meso and macro system level as the effects of this significant problem negatively impact the patients, organization, staff, and the community. The goal of The Joint Commission (2018) has been to provide a framework for hospitals to develop their patient safety system that allows staff as well as leaders to collaborate in eliminating complacency, building trust, creating mindfulness, treating each other with respect and learning from patient safety events.

Synthesis of the Literature

Quality documentation and hand-off communication have been essential for attaining and maintaining the continuity of quality care for patients in the emergency care setting. The emergency department has been considered a fast-paced, stressful environment for nurses and thus has the need for a more structured, standardized checklist for attaining accurate documentation of patient care and hand-off reporting. According to Milesky, et al, (2017), the National Patient Safety Goals has highlighted the need for a structured hand-off communication tool for reducing adverse errors, increasing timeliness, and dismissing vagueness that facilitates a clear understanding of a patient's condition and plan of care. According to the authors, hand-over was simplified when the information provided was delivered in a structured, focused, and concised format. The Joint Commission "in 2006", emphasized the necessity of a structured

format for hand-off communications and recommended SBAR (Situation, Background, Assessment, Recommendation) as the guiding post for hand-off communications (Colvin, et al, 2016).

To evaluate the effectiveness of the proposed evidence-based intervention, a comprehensive search was conducted to assess all the relevant studies that complied with the PICOT question; "For nurses working in the emergency department at a local hospital, does the implementation of the Institute of Health Improvement SBAR guideline as a checklist compared to unstructured hand-off forms help to improve documentation and hand-off communications among the emergency department nurses in 8 weeks?"

To answer the question and determine the effectiveness of the SBAR intervention, a systematic review was performed in several databases. Cochrane, Medline, PubMed, Joanna Briggs, and CINAHL were searched, and the relevant articles selected and reviewed. The results obtained, entailed both systematic reviews and empirical research. The inclusion criteria involved all studies conducted in the emergency department as well as an acute - care setting. Studies conducted in 2013 through 2018 "along with full text and English" were included in the search. The search consisted of keywords such as documentation, nursing documentation, SBAR, complete, hand-off communication, structured, standardized, checklist, emergency department, nurses, acute - care setting and improving outcome. The findings of the evidence were analyzed and then categorized into distinct groups such as education, checklist, collaboration, teamwork, and huddle.

Synthesis of the evidence was done using Cochrane Research Methodology for examining reliability, effects of the interventions, and the different GRADE levels. According to Khali, et al, (2016), the current methodology for linking evidence to action involves assessing qualitative,

quantitative, peer review and economic research for effectiveness, appropriateness, meaningfulness and feasibility in the healthcare setting.

Improving Documentation and Handoff Communication: Checklist

Robins and Dai (2015) highlighted that immanently technical organizations such as the aviation industry rely on hand-off checklists for documenting extremely crucial operational information that is communicated to ensure the high level of accuracy necessary, minimize the risk of errors and achieve a distinguished level of safety. Robins and Dai described a Randomized Control study that was completed in the PACU with the use of a checklist. Sixty participants were involved, and fifty-four hand-offs were completed with a total of twenty-four checklists. The results overwhelming indicated that the use of a checklist significantly lowered the rate of callbacks for clarification and increased adequacy in hand-offs. Another study by Pucher, et al, (2015), demonstrated that 19 credible studies of the use of a communication checklist for hand-over all emphasized improvements in patient safety and positive outcomes.

Improving Documention and Hand off Communication: Education

Kear, et al, (2016) discussed the critical importance of performing an effective hand-off communication in the nephrology unit designed for minimizing medical errors, and prioritizing patient safety. The authors highlighted that 80% of medical errors were attributed to inaccurate and inadequate hand-off information. A mixed method was utilized for retrieving data pertinent to hand-off communications between 827 nurses in the nephrology practice settings. Both descriptive and cross-sectional designs utilized fifty itemized closed ended questions with the patient hand-off tool from the Agency for Healthcare Research and Quality and the Joint Commission Hand-off Communication Tool. The sample population was selected from The American Nephrology Association and questionnaires were emailed to the nurses from the

association list (Kear, et al, 2016). Of the 827 questionnaires, 744 met the study criteria, while 83 were disqualified.

Results from the study emphasized the vital importance for a patient safety culture. Incomplete information for patient transitions was recognized in both qualitative and quantitative studies. The findings indicated that SBAR and verbal communication were utilized to achieve effective communication in the practice setting (Kear, et al ,2016). Results from the studies confirmed that nephrology nurses were experiencing similar problems as nurses in other acute care settings owing to the fast-paced chaotic environments, unplanned hand-offs and limited timeframe for reporting adequate and accurate patient transition information (Kear, et al, 2016).

The study emphasized that the use of structured communication tools such as the SBAR and I-PASS the BATON should be comprehensively employed for enhancing and inuring the hand-off communications. Additionally, face-to-face hand-off communications was essential, as well as the participation of both parties for ensuring that the information transitioned was adequate and limpid. Barriers to a successful hand-off communication should be addressed by educating the staff. Secondly, nurses need to be cognizant of the adverse patient events resulting from incomplete hand-off reports.

Holly and Poletick (2013), were convinced that properly educating staff on the use of SBAR as a structured standardized tool would dramatically improve communication, accuracy and adequacy of information transitioned. The authors discussed a Meta-synthesis that was performed on 16 categories that produced two synthesized findings that could be utilized as evidenced-based practice. The two findings were that the individual nurse influenced the patient care, nurse as the gatekeeper of information and hand-off information that was pivotal in the decision-making process. The authors suggested a structured hand-off tool and the absolute

necessity for educating all nurses on the hand-off process. The evidence highlighted the dire requirement for a framework that was standardized, designed to serve as a guide for complete reporting necessary for eliminating inconsistency, variations and inaccurate information (Holly and Poletick, 2013). Additional benefits highlighted by the author included written and structured tools, such as the SBAR, that serve as cues for reminding nurses of key information and findings that need to be reported, rather than relying on information recalled from memory. Suggestions such as printing of a single sheet with the documentation of a patient's demographics, current vital signs, labs and other pertinent data supplemented with the use of the Electronic Health Record complemented the verbal hand-off. Most of these EHR provide and permit printing of the standardized forms that can be transitioned to the next shift for reference (Holly and Poletick, 2013).

Other authors such as, Chaharsoughi, et al, (2014), identified SBAR as an essential tool complemented with role play as a teaching method for promoting effective communications skills. According to the authors a Quasi experimental method using a post-test design with control and an experimental group of forty nurses learning the SBAR via roleplay and lecture over a two-week period was conducted. The results demonstrated that roleplay was an excellent technique for teaching SBAR and promoting effective communication among nurses as well as encouraging safety and improved quality care for patients.

Improving Documentation and Handoff Communication: SBAR, Teamwork and Huddle

According to Martin and Ciurzynski (2015), a substantial number of lives has been lost annually owing to ineffective hand-off communications and teamwork. The implementation of standardized communication tools and strategies significantly has contributed to improving patient quality outcome and alleviate these annoying issues. The authors identified the use of

SBAR (Situational, Background, Assessment, Recommendation) and Huddle as two effective tools that would be conducive for improving hand-off communication among nurses in the pediatric emergency department (Martin and Ciurzynski, 2015).

The data for a qualitative study involved 32 nurses and two nurse practitioners, using structured observation, pre- and post-surveys. The outcomes measured were nurses' satisfaction, SBAR guided huddle, presence or absence of patient evaluation and verbalization of patient treatment plan (Martin and Ciurzynski, 2015). The result highlighted that 83% of the patient encountered included a joint evaluation, SBAR with Huddle took place with 86%, and communication of patient treatment was verbalized between nurse and nurse practitioners in 89% of the cases. Teamwork, communication, and nurse satisfaction were positively impacted amongst the team. The authors highlighted that the project demonstrated great potential for improvements in the quality of patient care and efficiency with the utilization of structured communication strategies. Nagammal, et al, (2016), highlighted that the SBAR tool provided the healthcare team with a framework for communicating patients conditions, facilitated the gathering, organization and exchange of information and an effective strategy for improving teamwork. According to Martins, et al, (2017), effective leadership and communication were essential especially in emergency and the SBAR should be utilized to provide information in person or over the phone.

Another study that focused on teamwork was conducted by Randmaa, et al, (2016); the findings emphasized the eminence of SBAR communication utilized in other disciplines to foster continuous teamwork and collaboration in high-risk organizations. The author referenced a study that was conducted in the clinic setting. Strategies for facilitating the implementation of the study included modification of pocket SBAR cards accompanied with in-house training

courses for the staff, hand-outs of informational materials and observation for a seven-month period. 80% of the staff were trained while continuous training was provided for others. The author discussed that the result of using the SBAR showed dramatic improvements in the accuracy of information over time and facilitated enhanced collaboration between nurses and doctors, as well as a notably increased climate of safety and reduction of reported incidents accredited to medical errors.

Improving Documentation and Handoff Communication: Bedside Handover

Kerr, et al, (2013), noted a pre- and post -intervention study that was done on three acute wards where standardized bedside hand-over was utilized for improving completion of nursing tasks and documentation. A total of 754 cases were analyzed and some exhibited dramatic improvement in nursing tasks and documentation.

Other credible studies such as Millar and Sands (2013) was done in a mental health setting that utilized standardized communication tools such as SBAR that sought to promote consistency in patient hand-off communication. Muller, et al, (2018), further discussed findings from a systematic review that demonstrated how the use of the SBAR improved patient safety especially when utilized for structuring communication over the phone. In conclusion, Colvin, et al (2016), highlighted the result of the SBAR (Situation, Background, Assessment Recommendation) tool based on a study that was conducted in the ICU, when utilized in the setting evinced a reduction of adverse events from 90% to 40% per 1000 patients' days and drug events from 30 to 18 per 1000 patients' days.

Practice Recommendations

Quality documentation has been paramount in the hand-off communications process between nurses to assure continuity of care and the prevention of adverse events. Based on the

findings, increasing the rigor in quality, the accuracy of documentation and hand-off communication integrated with the SBAR guideline tool as a checklist is obligatory for organizations seeking positive outcomes.

To achieve and maintain the benefits of a standardized structured SBAR checklist, the need for leadership support, frequent auditing of charts, feedbacks from audits, continuous education and visual reminders of the documentation tool were highly recommended. According to Kerr, et al, (2013), the establishment of a standardized protocol, clinician engagement, and formal education were effective strategies for successful communication hand-over transformation. Pucher, et al, (2015), argued that improvement in patient communication was achieved with the use of a checklist.

In summary, the results of the findings highlighted the importance of utilizing a standardized structured tool to improve documentation and hand-off communication among healthcare staff. The following interventions that were extracted from the study are SBAR, checklist, teamwork, and huddle. One similarity of the studies was that the selected intervention, whether SBAR, checklist or bedside hand-over must be standardized, structured and should be implemented as a guide for improving the rigor and effectiveness of the outcome. Other benefits that were extracted from the study were: improved patient centered care highlighted by Kerr, et al, (2013), improved team work and collaboration with Huddle (Martin and Ciurzynski, 2015), and Colvin, et al, (2016), reported a 40% reduction in adverse event when SBAR was utilized in the acute care setting.

The strength of the study noted was the additional knowledge gained on the varied patient-centered outcomes that was achieved from the implementation of the SBAR checklist and hand-off communication. These valuable outcomes would additionally enhanced organizations

and the patient experience in a positive way. Areas of weakness in the study observed were the small amount of information available for specific documentation tools utilized in the ED.

Limitations of the study existed on the timeliness of documentation, especially with regards to real-time documenting. Additionally, there were not many studies related to nursing documentation in the ED and the keywords choice limited the search. Recommendations developed from the study included the use of constant collaboration, leadership support, continuous education, auditing and feedback on chart reviews, conducive working environment and available resources to assist with the implementation of the SBAR checklist and to maintain the change.

Evidence-Based Practice: Verification of Chosen Option

Quality improvement initiatives helped to promote the need for change in the healthcare industry. The primary goals of these initiatives were to provide safe quality care, improve population health, improve patient experience and reduce health care cost, (Weston and Roberts, 2013). Based on all the information obtained, the selected evidenced-based intervention appropriately fitting for the organization would be the use of the Institute of Health and Improvement SBAR guideline as a checklist to improve nurses' documentation and hand-off communication for oncoming emergency department nurses and inpatient nurses. The SBAR checklist required customization for accomplishing the documentation needs of the nurses in the ED. The Quality Improvement project involved a theoretical framework to guide the change process for achieving success.

CHAPTER 2: THEORETICAL FRAMEWORK

Theoretical Framework

Practical application of a Quality Improvement project relies heavily on a robust conceptual framework or model utilized as a guide in the execution of a planned change. Planned change is described as purposeful, calculated and considered a collaborative effort to improve the system, (Mitchell, 2013). Planned change involves the use of strategic methods to enhance nurses' productivity and decrease stress from turbulence in the environment, (Huber, 2013). Owing to the fast-paced and stressful environment in the emergency department, the improvement of documentation in the ED required a planned change to achieve a culture of patient safety and positive health outcome as well as satisfactory result for the staff and the organization. The initiative to improve quality and safety involved the implementation of the SBAR (Situational, Background, Assessment, Recommendation) guideline checklist for improving documentation and hand-off communication. The Theory of Change Management by Kurt Lewin (1951) was deployed to guide the change project.

Lewin's Change Theory on Change Management has been in existence since 1951 and is successfully utilized worldwide. The change model has been considered the oldest, most applicable robust theory that has been used for groups, personal and organizational change (Kaminiski, 2011). Lewin inferred that the success of a project involved the use of the three concepts that were outlined in the Change Management Theory: Unfreezing, Freezing, and Refreezing, (Malekazadeh, et al, (2013). Lewin’s three concepts were employed in directing the change in the current practice to the new intervention utilizing the SBAR checklist and handover to maintain quality documentation in the ED among nurses. According to Wojciechowski (2016), owing to the complexity of the healthcare system, inter-professional collaboration has

been paramount in implementing and sustaining change necessary for achieving a satisfactory patient outcome.

Unfreezing defines the problem and the need for change in the organization was identified. As part of the process, restraining forces, motivation and readiness to change occur by bringing awareness to the challenge and then appropriately educating staff on the need for change was performed (Wojciechowski 2016). In the first stage, factors and forces that maintained the status quo were unfrozen and removed (Malekazadeh, et al, (2013).

The next stage of the change is Moving, in this moving stage the change agent after acquiring adequate information on the problem, met and discussed solutions and the benefits of change with the main stakeholders (Wojciechowski, 2016). Nurses were educated and coached on how to use the new SBAR checklist during hand-over communication to change behavior. Malekazadeh, et, al, (2013), highlighted that involving the nurses in the decision making empowered them so that the optimal change strategy can be successfully implemented.

Refreezing involved the integration of the new product into the system for achieving the stabilization desired, as well as ensuring that the new initiative is fully utilized and adopted and positive outcomes realized (Wojciechowski,2016). The change agent encouraged the staff to acquiesce to the newly learned behavior and prevented them from relapsing to the old status quo (Malekzadeh, et al, (2013). In this phase, nurses were observed and monitored for their use of the SBAR checklist during handoff communication at the bedside.

Change Model

Change is inevitable especially in the healthcare system where change is constantly happening. In such a complex system the need for a planned change to bring about stabilization

for improving nurse documentation in the ED was essential. Planning is considered critically important for an environment that is stressful and chaotic such as the ED when executing a change. The theory that was appropriate for guiding this change in the organization was Lewin's Theory of Change. Lewin's Theory of Change is a simple three-step process that involve Unfreezing, Moving and Refreezing. This theory was selected based on its high credibility and reputation of being around a long time and has been greatly used in healthcare organization for achieving positive outcomes. According to Sutherland (2013), Lewin Theory have led to a better understanding of how the change theory have affected the organization and have helped frontline stakeholders overcome fear and resistance with a well-thought plan and active staff participation. The theory sought to assist nurses through the transition process as well as identifying strengths and resistance before implementing change (Sutherland,2013). The utilization of Lewin's Theory of Change assisted the strengthening of the implementation of the SBAR checklist for improving documentation and hand-off without failure (Sutherland, 2013).

Step 1: Unfreezing

Working in a busy healthcare environment such as the ED require nurses to have and utilize innovative tools that offer structure and ease of use to safely provide effective care. Information on the implementation of a structured SBAR tool to be used during hand-off communication was given to all the frontline leaders and nurses about the change. Vines (2014) explained that the reasons for the change and the anticipated outcome should be communicated to the staff for winning their buy-in. Nurses' involvement in the decision-making process and planning empowered and motivated them on the importance of the change. The benefits of patient safety, job satisfaction, and the working environment were highlighted. Additionally, the process helped in alleviating fears and doubts that have caused resistance to the change. The discussions

included listening to the frontline nurses about restraining forces such as time, acuity level of patients and resources that might be barriers to the adoption of the change. The driving forces behind the change were identified as leadership support towards the change, time allocation for training and staff support.

Step 2: Moving Phase

This stage includes planning for the implementation of the SBAR checklist for handoff communication and documentation. The evidence supporting the change was discussed and goals and objectives to help achieve the change were determined. Educational training and guidance on documentation were provided for staff, target dates scheduled, and appropriate strategies were developed to help overcome resistance. According to Sutherland (2013), arranging appropriate timelines and ensuring reliability and availability of necessary equipment were important for avoiding workflow disruption. Soliciting the support of the nurse leaders and educators was organized for their assistance and guidance in the roll out and utilization of the SBAR checklist at the bedside rounding. Additionally, the change agent utilized transformational leadership skills by continuously providing feedbacks, ongoing support and creating an environment that promoted effective teamwork and the flow of information.

Step 3: Refreezing

Refreezing is the final step of the change process. The use of SBAR checklist during handoff communication was integrated into the practice setting and was assimilated as the norm and culture of the organization. According to Bartas, et al, (2016), this stage of the process involves realigning policies to promote the continuation of the change. Nurses were required to utilize the SBAR checklist during hand-off communications at the change of shift report and for patient transfers. According to Holly and Poletick (2013), structured tools such as the SBAR, served as

a cue for reminding nurses of the critical information and findings that should be reported. Nurses were observed by the implementation team during hand-over to ensure utilization of SBAR checklist to assure compliance. According to Vines (2014), the implementation of mandatory continuing education was important for achieving compliance. Providing feedback and updates on the outcome of the innovation were important for the staff and stakeholders. Vines (2014) suggested that monthly meetings with staff motivated the nurses to perform effectively. Additionally, the organization was encouraged to maintain the new practice and competency by making it apart of their monthly performance evaluation. The DNP project on documentation was a required necessity for the emergency department to ensure that the information delivered was of great quality to continue the care of the patient. Utilizing Lewin's theory on Change Management provided clear guidance for the planned project in a concise and effective manner for improving organizational goals.

CHAPTER 3: PROJECT DESIGN AND METHODS

This chapter discuss the details of how the project on improving documentation in the emergency department came into existence and the necessary preparation that was executed for meeting the needs of the organization. Organizational support was discussed along with the letter of support allowing the change agent the permission required for implementing the project. Additionally, the impact of the project on the main stakeholders was highlighted. A SWOT analysis highlighting the strength and weakness of the organization along with potential threats and opportunities were included. The eight-weeks duration of the project was reviewed along with the plans and resources needed for executing the project successfully. The role of the DNP student throughout the implementation phase was defined along with the selected superusers constituting the implementation team. Plans on how to sustain the project as well as overcoming barriers were clearly established and highlighted.

Organizational Need

Following discussions with the emergency room's clinical nurse educator, the concern of low staff satisfaction scores and incomplete documentation was highlighted. A meeting was arranged with the department's nurse manager and the need for a change to improve documentation among the nurses was discussed. The nurse manager's appetency is that the planned change would reinforce and encourage a culture of safety and contribute to improving patients' experience and staff satisfaction.

Organizational Support

A letter of support for implementing an evidence-based intervention that will contribute to improving nurses' documentation was received from the Educational Department. Computer

access for chart auditing along with training on the documentation platform was also granted (see Appendix G).

Project Stakeholders

Nurses, patients, the organization, and the community were the intended targets that has been impacted by the project. The change project on documentation has contributed to improving patient safety as well as the working environment for the nurses. The organization should benefit financially along with improvements in the Hospital Consumer Assessment of Healthcare Providers and System (HCAPS) scores. External forces such as The Center for Medicare and Medicaid Services should observe a reduction in readmission rate, and the community will be provided with a health care system that deliver safe, quality care.

SWOT Analysis

The SWOT analysis tool (see Appendix F) was utilized for assessing the strengths, weaknesses, opportunities, and threats affecting the organization. According to Hanfai and Fatam (2015), SWOT analysis is a means of helping organizational managers to analyze organizational situations and to develop evidence-based strategies and interventions to improve efficiency, safety, and positive outcome for all the stakeholders involved.

Strengths

The practicum site has been the largest of the seventeen campuses in the area and has gained nationwide recognition by Leapfrog for Safety and *US News* as one of America's Best Hospitals. An additional characteristic of strength noted was the department's efforts in exploring evidence-based intervention to improve documentation in their pursuit of quality care and safety of the patient and the working environment.

Weaknesses

Weaknesses identified at the practicum site were the delayed documentation of patient care and nurse shortages. Such shortages consequentially caused an increased patient workload, work fatigue, and increased the risk of adverse effects. The working environment had a need for change and for additional nurses for countering these deficiencies.

Opportunities

The opportunities that the practicum site attained from the DNP project included an improvement in patient-nurse relationship, development of a healthy, safe working environment, and cooperative teamwork. The intention of the project was to achieve an overall satisfactory outcome for everyone involved. The practicum site has an extensive educational resource center that was accessible for developing awareness of the necessity of quality documentation continuously.

Threats

The perpetual shortage of nurses may potentially adversely affect the working environment of the organization. Factors such as the increased acuity level of patients and workloads could overwhelm the nurses thereby resulting in poor job satisfaction and eventually poor retention rates. According to Carthon, et al, (2015), studies have shown that the lack of time and shortage of nurses contribute to the omission of basic nursing care that result in a poor patients' outcomes.

Barriers and Facilitators

Negative reactions to change could be as result of the rapid and constant changes in the healthcare system for improving patient care. The presence of leadership support accompanied by a transformational style, incessant communication, impartial feedback, and committed staff

involvement in the decision making and training was utilized to overcome and facilitate a smooth transition to the change. Bleser, et al. (2014) noted that a shared vision in the organizational change, as well as a need for the culture of organizational support, are essential components for gaining buy-in from staff.

Project Schedule

The duration of the project was for eight weeks. The first week included the introduction of the proposed intervention; weeks 2-3 involved pre-intervention that included completing the SBAR surveys; weeks 4-7 involved implementation and troubleshooting; week 8 encompassed post-intervention and evaluation for monitoring compliance and success (See Appendix C).

Resources Needed

This project's cost-effective budget included refreshments during the training program as well as stationery supplies for chart auditing and the SBAR template. Other infrastructures and supplies were readily available for use. Nurse leaders enrolled for the day and evening work shifts were the key participants of the project (See Table 1).

Project Manager Role

The DNP student's role as a change agent was to ensure that the needs of the end users were promptly addressed, providing appropriate feedback, facilitating effective communication, troubleshooting, and offering guidance for the success of the project.

Plans for Sustainability.

Strategies for sustaining the project included chart auditing along with providing feedback from the audit to the staff, to increase their knowledge about the progress of the study. The presence of nurse leaders offering support, continuous education, and visual reminders regarding the importance of documentation were utilized. Other strategies included recognitions

and rewards for staff that were in full compliance with the new SBAR guideline tool for improving documentation.

Project Vision, Mission, and Objectives

The mission statement of the DNP project was to advance a culture of safety that would promote and inspire effective changes for nurses' documentation in the emergency department. The aim was to optimize patient care and hence achieve quality patient outcomes. The vision was to cultivate a culture of change and encourage full participation in the change process at the organizational level such that the change could be effective throughout the system. To achieve such a vision, both short and long-term strategies were employed including:

- Identifying factors that contribute to incomplete documentation among nurses.
- Discussing the impact of the problem on the nurse's working environment
- Reviewing articles on best practice that would address the problem and comparing them with current practices.
- Discussing with the main stakeholders the feasibility of the proposed intervention and gain buy-in
- Educating and training staff on the recommended intervention
- Implementing and evaluating the effectiveness of the planned intervention
- Maintaining the change.

The overall mission of the change project and vision was in unison with the organization's mission statement; "To extend the healing Ministry of Christ" and the vision that is "To be a global pacesetter delivering pre-eminent faith-based healthcare." According to Gulati, et al, (2016), a vision statement is important for the success and transformation of the organization and provide leaders with the opportunity to think about

their hope and aspiration for the organization. Both the organization's project mission and vision statements strive to provide quality patient care by utilizing current evidence-based practice to affect change that has been geared towards keeping the patients safe while nursing them back to good health.

PICOT Question

The following PICOT question served as the basis for the proposed DNP project on improving documentation and hand-off communications. "For nurses working in the emergency department at a local hospital, does the implementation of the Institute of Health Improvement SBAR guideline as a checklist compared to unstructured hand-off forms contribute to improving their documentation and hand-off communications among the emergency department nurses over the 8 weeks period?"

Population

The project was conducted in the emergency department and the final sample involved 30 registered nurses working on all shifts in the emergency department. The intention was to incorporate all the nurses since they were all involved in documenting and communicating patient care. The nurses in the ED were wholly aware of this problem of incomplete documentation and the ambitious plans for improving the process. The assistant nurse managers and nurse educator were part of the team to foster buy-in from the nurses. The issue of incomplete documentation was discussed during energizer and at shift change. Participants that were full time, per-diem and part-time nurses were included in the study while nurses who floated from inpatient units, administrators and patient care technicians were excluded.

Intervention

The intervention proposed was the Institute of Health and Improvement SBAR guideline that has been widely utilized as the framework for guiding information exchanged between healthcare teams, on what to report and how. A plethora of studies have indicated the SBAR's suitability, as the tool has been tested in a variety of healthcare settings and has been proven to deliver a positive impact on patient safety, improved communication, served as a cue for reminding nurses of the important information and findings that need to be reported rather than reliance on information recalled from memory, improved nurses' satisfaction and enhanced teamwork and inter-relationship (Martin and Ciurzynski, 2015). Additionally, SBAR has proven to dramatically decrease negative patient events (Randmaa, et al, 2013). Muller, et al (2018) discussed the findings from a systematic review that demonstrated how the use of the SBAR improved patient safety especially when used to structure communication over the phone. Other studies such as Cornell, et al, (2014) highlighted the benefits of utilizing the SBAR in providing nurses the opportunity to stay focused during hand-off communication, improved workflow, reduced time spent retrieving patient information as well as providing the consistency in patients' information exchange. The implementation process of the intervention included educating and instructing nurses on the use of the SBAR guideline and checklist for documentation and hand-off communications. The nurses were presented with a ten-minute PowerPoint presentation on the SBAR's purpose and function as well as a case study scenario at the end of the educational session for reinforcing the SBAR guidelines and the use of the checklist. Superusers were trained and utilized after the educational sessions to augment the rollout of the SBAR guideline and checklist.

Additionally, the assistant nurse managers and nurse educators as champions were utilized for mentoring and guiding staff correctly with the evidence-based intervention for achieving compliance. The DNP student as a change agent was responsible for collaborating and communicating with the team and staff to provide useful feedback.

Comparison

The current practice of the emergency department lacked the standardized and structured checklist that would provide consistent and accurate patient information during the hand-off communication process at the bedside and during transitions. According to the Institute for Health and Improvement (2016), the SBAR guideline has been commonly used as a framework for healthcare teams communicating patient conditions among each other and to organize their information for creating a culture of patient safety. The IHI (2016) highlighted that the SBAR has been widely implemented in healthcare systems such as Kaiser Permanente.

Outcome

The outcome of the project was appraised by observing the nurses on all shifts during the hand-over process to determine if they were consistently utilizing the SBAR checklist. Nurses were observed for the outcome of improvement in communication, patient safety, nurses' satisfaction, and reduction in time during hand-off communication. The first week involved administering the pre-survey questionnaires to all staff. An SBAR assessment questionnaire, pre and post, was used to evaluate nurses' perception of the effectiveness of the SBAR tool on communication adapted from Sears, et al, (2014). Permission to use the SBAR assessment tool was granted by the authors as displayed by the letter found in Appendix E. The pre-survey was completed on paper during the second week before the implementation phase and post-implementation using a 5-point Likert scale consisting of "strongly disagree" to "agree"

responses. During the post- intervention phase, the SBAR Assessment questionnaire was reused to determine the nurse's knowledge and use of the SBAR. The implementation team distributed the questionnaire over a two-week span on all shifts. The completed surveys were secured in an envelope for the compiling of data by the DNP scholar to measure the nurse's perception and knowledge based on hand-off communications and documentation. The reliability and validity of the SBAR assessment tool was verified by offering the same test to the same group during the post intervention phase.

Time frame

The timeframe for the project was eight weeks where educational training, pre and post surveys, implementation, evaluation, and feedback were conducted.

Feasibility

Completion of the DNP project within the eight weeks' timeframe was achieved by comprehensive planning. Strict adherence to the project schedule was required to achieve task completion. During the first two weeks the questionnaires were distributed to the nurses on all shifts. Educational training on SBAR was provided during a munch and learn session. The DNP student was available for providing guidance and feedback during the implementation phase. One barrier that the DNP student encountered was coordinating the four different shifts in the ED setting (7-7pm, 3pm-3am, 7pm-7am, 11pm-11am). Strategies for overcoming this hurdle was to solicit the help of the nurse educator and assistant nurse manager on each shift to aid with the distribution of the questionnaires to the participants.

Sample and setting

The emergency department at the practicum site has been one of the largest in the country with 62,000 square feet. The setting has 50 large treatment rooms with private bathrooms in the

acute care patient rooms. The ED setting has been offering 24 hours on-call specialized services such cardiac, neurology, trauma, neurosurgery, orthopedics, pediatrics, Internal Medicine, and a state-of-the-art chest pain center that delivered care for heart attack patients. The clinical setting treated approximately 90,000 patients per year. Excellent collaboration between the ED and other inpatient units allowed for satisfactory patient care. On entering the ED, patients were first politely greeted by the triage RN that assessed the patient and prioritized their care based on the needs of the patient (Florida Hospital, 2018). Ebrahimi et al. (2016), describes triage as sorting or prioritizing the patient care to ensure the appropriate treatment. There were approximately 180 staff in the ED that included RNs, paramedics, Emergency Medical Team members, Patient Care Technicians (PCT) and Environmental Specialists. Approximately 130 RNs worked in ED that included part-time, full time and per-diem nurses.

The mission of the organization is "To extend the Healing Ministry of Christ" while the vision is "To be a global pacesetter delivering pre-eminent faith-based health care." (Florida Hospital, 2018). The organizational culture has always been to create a culture of safety that supports the project to improve nurses' documentation in the ED by utilizing the SBAR checklist a structured and standardized checklist for effectively communicating and continuing patient care safely. The mission, vision and organizational culture were to provide quality care that would bring about safe patient care and positive outcome.

Implementation Plan/Procedures

After obtaining the necessary permission from the leadership team in the emergency department, the implementation planning/procedure commenced. Selection of the team was done and included the nurse educator as well as day and evening assistant nurse managers that were part of the quality improvement team on documentation. The team met and collaborated

primarily for improving documentation by the successful implementation of the proposed change. The implementation plan involved a three-phase approach over the period of 8 weeks that included the pre-implementation phase, educational session, implementation, post-implementation and evaluation. The DNP scholar endeavored to develop an atmosphere that was conducive to learning and fostered a culture of change thereby achieving buy-in from staff. Adequate information on the project was provided to nurses along with adequate time. All staff were encouraged to participate in the study to ascertain the feasibility of the SBAR tool's use in the ED.

Pre -Implementation Phase

The location of the project was the ED setting and has been one of the most prominent ED in the Central Florida region. There were 50 large treatments rooms; the ED also offered 24 hours on-call specialized treatment ranging from chest pain to orthopedics care. The subjects for the study involved 30 nurses (full time, part-time and per-diem) working in the department with the exclusion of all float nurses, patient care technicians (PCTs) and nurse administrators. The subjects were recruited by sending out an email to all informing them of the project details and its aim. The assistant nurse manager and nurse educator that were the key participants of the quality improvement team assisted in the recruitment phase. Consent for the project was voluntary; however, a consent letter was attached to the questionnaire for the participants to sign.

A pre- and post-intervention survey design was used, and the assessment tool was adapted from Sears, et al, (2014). The tool was used for collecting the data for evaluation. The process involved administering questionnaires before and after the intervention in order to fully assess the effect on the outcome. The main objective of the study was to evaluate the effectiveness of the outcome of the SBAR checklist tool in improving nurses' documentation and

handoff communication in the ED. The reliability of the data collection tool was in good standing since it was originally developed and verified at the Toronto Rehabilitation Center and later adapted by Sears et al. where the tool was used across a multiple-site acute healthcare facility. The questionnaires were utilized for assessing the effectiveness of the SBAR tool on communication. The validity of the SBAR tool has been widely known to have positive impact on effective communication and patient safety (IHI, 2016).

The first phase was the pre-implementation phase that involved administering the SBAR assessment questionnaire to the nurses in the ED. The polls included answer choices ranging from “strongly disagree” to “agree” about their use of the SBAR tool. The questionnaires were made available in the unit for the nurse leaders to issue to their nurses. The questionnaires were completed and returned in a sealed envelope to avoid violation of privacy and biases. The DNP student gathered the information and conscientiously analyzed the data. During the pre-implementation phase, chart auditing on the ED two most essential items, cardiac telemetry monitoring and critical lab values were performed for assessing the completeness of nursing documentation. Patients’ names and sensitive data were excluded in order to protect their privacy.

Educational Training

The first phase also included educational training; nurses received training on the use of the SBAR tool. A PowerPoint presentation on the use of SBAR as an integral tool for improving documentation, hand-off communication and patient safety was presented with the aim of targeting the frontline staff and empowering nurses with the prerequisite knowledge necessary to demonstrate the benefits of the tool. The presentation was displayed during huddling for ten minutes and was additionally provided to nurses via email during the second week of the project.

Implementation Phase

During week 4-6 of the implementation phase, the selected team assisted in the rolling out of the new SBAR checklist that was specifically modified for the ED. The team that consisted of the DNP scholar as the project lead, the nurse educator and assistant nurse leader, were available and accessible as champions for assisting and mentoring nurses with their questions and doubts they had during the process.

Additionally, two superusers from the nursing team were selected for their assistance in motivating their team members. As mentioned, prior, the ED had four different work shifts with a maximum of 130 registered nurses, some being full time, part-time and per-diem; the implementation team accommodated everyone.

Post -Implementation

The post-implementation phase occurred from week 7 to 8. The post-implementation questionnaire was administered for assessing the users' perception of the new SBAR tool. In addition, post chart audits were generated for evaluating the quality of documentation. The pre- and post-intervention information was then reviewed and compared to assess the results.

Data Collection Procedures

A pre- and post-questionnaire design was used to gather the data for evaluation. The study aimed to evaluate the effectiveness of the SBAR checklist tool for improving nurses' documentation and hand-off communication in the ED. The ordinal data was based on "strongly disagree" to "agree" responses and were used in deciphering the results of the data obtained. According to Beacom (2018), ordinal data stands in the order of ranks, but the measurements are not quantitative. The pre and post questionnaires were graded on a five-point Likert scale. Extraneous variables determined the barriers that may affect the change project. The DNP

student identified the different shifts that were available in the ED as an extraneous variable. The implementation team ensured that everyone was targeted and received the same information to assure consistency. Another external variable identified was the periderm nurses that only attended work once per week, this could have created a delay for them receiving and returning the information in a timely manner. The arrangement was made to email the PowerPoint information to all the nurses in the ED.

The statistical data gathered was analyzed using Descriptive Statistics. The design utilized for the research was a non-experimental design. Polit and Beck (2017), describe the design to have a pre- and post-intervention without a control group. The use of a statistician for assisting in selecting the appropriate statistical methods was sought for assessing and deriving the answers to the project question.

Procedure

The project was conducted in the emergency department at a local hospital for a duration of eight weeks. The details of the project schedule are in Appendix C. Of the 130 nurses in the ED a sample size of 30 volunteered for the project. The DNP student demonstrated transformational leadership qualities such as active listening, collaborating with the team, providing relevant information, constant communication, and prompt feedback to achieve buy-in that drove the project's success. Bleser, et al, (2014), noted that the shared vision of organizational change was an important concept for gaining buy-in of the staff as well as a need for a culture of corporate support. Soliciting the help of leaders, champions and the involvement of the group helped in persuading end users to accept the change. The data was collected from the three phases of the project and was calculated independently. The sample size of 36 nurses working in the ED full time, part time and once per week volunteered for the study. The final

sample size at post survey was 30 nurses. A data collection sheet was used to collect the information and helped in organizing the results that were displayed. All participants in the study were provided with training after the pre-questionnaires. Leadership support throughout the implementation phase was made accessible to all nurses. Superusers were appropriately recognized and rewarded. Feedback was given to all the nurses and team members that participated in the change project. The DNP student gave a vote of thanks expressing appreciation to everyone for their full support and participation at the final phase of the project. Follow up and contact information were provided for any additional queries.

Recruitment and Selection

The project was approved by the management team in the ED and commenced after IRB approval by recruiting the participants. All nurses working in the ED were recruited for the Quality improvement project utilizing the SBAR checklist to improve nurses' documentation in the ED. A convenient sample of 36 participants from the 130 nurses working in the ED volunteered, 31completed the consent form and was utilized in the project for the implementation of the SBAR checklist. Consents were obtained by requesting the nurses' participation in the study with the understanding that they could opt to withdraw at any point. Assurance was provided to the staff guaranteeing that their information would be kept anonymously, and an envelope provided for returning the report securely. A non-experimental, pre and post design was used for the study. An ongoing formative evaluation was performed on a weekly basis to ensure that the planned schedule was on time. The summative assessment was done at the end of the project to assess its overall success.

Data Analysis Plan

The evaluation of the planned project was carried out in the form of evaluating the result of the completed pre- and post-questionnaires and scorecards were evaluated for the desired outcome. Charts were reviewed for completeness of patient care information; post-intervention data was compared with the pre-intervention data received. Nurses were also observed for the correct use of the checklist and to assess if they were meeting the outcome of the PICOT question, "For nurses working in the emergency department at a local hospital, does the implementation of the Institute of Health Improvement SBAR guideline compared to unstructured hand-off forms help in improving documentation and hand-off communication among the emergency department nurses in 8 weeks?"

The result obtained at the post implementation phase was a final count of 30 nurses working in the ED. Thirty-one participants completed the pre-survey while the post intervention survey was completed by thirty nurses. Both the pre- and post-questionnaires were retrieved from the sealed envelopes for evaluation of the desired outcome of improved nurses' documentation. The data collected was logged using the computer software, Statistical Package for the Social Science (SPSS) version 25 to evaluate and compare the differences between the pre- and post-questionnaire. Descriptive statistics was used to analyze the polls. Once the project was completed, the assistance of the statistician was accessed for guidance to ensure the accuracy of the results to assess for the desired outcome. Bar charts, tables and figures were utilized to display the results for everyone to evaluate and easily comprehend the outcome.

Instrumentation

The SBAR checklist that was used in the implementation phase is presented in Appendix G. The SBAR tool as a checklist was adapted from the Institute of Health with permission

granted and was made available for public use for patient safety but not for republishing. The tool was customized for the project to be used in the ED. The pre and post questionnaires were adopted from Sears, et al., (2014). The permission to use letter is presented in Appendix E. The reliability and validity of the instrument are positive as the tool has been used by other healthcare facilities to achieve remarkable outcomes that are consistent. The inquiries required participants to respond by selecting their responses ranging from strongly disagree to agree on the Likert scale. An acceptable and clinically significant improvement of greater than 5% was required while less than 5% signified no improvement (Sears, et al., 2014).

Instrument Reliability and Validity

The reliability and validity of the questionnaire instrument was confirmed to be positive as the tool was developed and has been verified in several facilities and have shown stable and consistent results especially in areas of patient safety, nurses' satisfaction and effective communication. According to Heale and Twycross (2015), validity is the extent to which the concept is accurately measured in a quantitative study while reliability is the accuracy of the instrument and the consistency of the measurement.

Ethics and Human Subjects Protection

The ED leadership staff was made fully aware of the project details and objectives. Data was gathered from the charts and observations of the participant done using the SBAR checklist. Participant's identities were kept anonymous to ensure privacy by placing the information collected in seal envelope that were locked in a filing cabinet until the completion of the project at which point the data was shredded in adherence to the Health Insurance Probability and Accountability Act (HIPPA). All participants were nurses working in the ED, the aims and

objectives of the project were discussed, additionally nurses had the right to self-determinate. Consent from the IRB was sought to avoid causing harm to the participants.

CHAPTER 4: RESULTS AND DISCUSSION OF DNP PROJECT

Nurse to nurse hand-off communications has been a pivotal aspect that forms the basis of all components for safe patient care, thus if this process is not properly executed the resulting patient care and outcome could be disastrous. Of major concern was the problem of incomplete documentation of patient care in the local emergency department that has often led to delayed patient care and unsatisfactory result for all parties involved. Such misfortune has led to thousands of people dying each year in hospitals attributed to medical errors, that is ranked fifth on the list of the National Center of health Statistics top ten causes of death in the United States (Gore, et al,2015).

Owing to the negative impact on patients' outcomes, the nurse leaders of the emergency department proactively sought effective evidence-based measures for addressing this problem. Hence the recommendation of the Institute of Healthcare Improvement SBAR (Situation, Background, Assessment, Recommendation) guideline as a checklist implementation directed at addressing this lingering issue. According to Ransom and Winters (2018), many highly notable organizations utilized standardized mnemonics such as the SBAR and I-Pass when performing hand-off communications to prevent sentinel events. The authors stated that The Joint Commission cited communication errors as a fundamental contributing factor to two in every three sentinel events.

The purpose of this section was to interpret and present the findings from the pre and post intervention and post evaluation survey on the use of the IHI SBAR tool as a checklist and its effectiveness for nurses' documentation and hand-off communications. Documentation and hand-off communications have been an essential element that set the stage for safe and effective patient care. Utilizing a structured format of communication such as the SBAR checklist

provided a validated structure for communication while creating a culture of patient safety in the clinical setting.

Summary of Methods and Procedures

Methods. A pre- and post-questionnaire design was utilized for gathering the nurses' responses on the use of the SBAR checklist to improve nurses' documentation and hand-off communications. Ethical approval from the IRB and permission from the nurse leaders of the ED from the selected hospital were obtained after which all registered nurses in the ED were invited to participate in the pilot study, 31 nurses volunteered. The participants remained anonymous, and a number identifier was assigned to each participant for the purpose of pairing the pre and post-data accurately. For the quality and improvement project, primary data collection in the form of a pre and post intervention and post evaluation surveys were employed for collecting the data. The pre and post SBAR assessment tool was developed and adapted from Sears et al. (2014). The tool was tested for reliability and validity in a multi-site healthcare organization that lasted for 1 year. The pre and post intervention questionnaires consist of seven itemized Likert styled questions ranging from strongly disagree to strongly agree relating to SBAR communication. Another form of primary data collection method utilized in the project was the SBAR observation tool used during hand-off communications to ascertain that the SBAR checklist was correctly applied and fully completed.

Procedure. The procedure for the project occurred in three phases. After garnering buy-in from the nurses in week 1, 36 (N=36) participants volunteered to participate in the study. Informed consent was obtained from 31 of the participants (Appendix G) followed by the distribution of the Pre-SBAR Assessment questionnaires adapted from Sears, et al, (2014) (Appendix D) to the nurses for completion during week two. During week 3 of the pre-

implementation phase, following the collection of the pre-survey a 10 minute PowerPoint Presentation (Appendix H) was given to the 31(N=31) participants on the proper use of the SBAR checklist as well as an overview of the project. Following the completion of the educational session in week 4, the SBAR checklist was then introduced to 30 participants in the ED to be used on each shift during hand-off communications and as a visual guide to assist with documentation. One participant was excluded because of leadership promotion.

The SBAR checklist utilized was paper-based and was comprised of four major components: Situation, Background, Assessment and Recommendation (SBAR). The SBAR, has been a ratified communication tool that is highly commended by the Joint Commission, IHI and other organizations to provide structured communication (Gausvik, et al, (2015). According to Gausvik, et al, (2015), communication has been identified by the Joint Commission as one of the major root causes of 60% of sentinel events and the top two contributing factors in an analysis of 70 medical mishaps. The theoretical framework developed by Kurt Lewin, theory of change was used to guide the Quality and Improvement Project during implementation to help mobilized the change. Huddling was performed before and after shift changes and was done during evening visits to encourage the participants on the importance of utilizing the tool. Participants utilized the SBAR checklist during the shifts, ensuring that all components of the SBAR tool and key areas pertinent to the patient was performed. Frequent communication and feedback took place throughout the four weeks of implementation of the tool. Additional data was obtained by conducting six informal and formal observations of hand-off communications with 12 (40%) of the participants to determine if they were utilizing the four components of the SBAR tool correctly and provided valuable feedback. Participants were observed utilizing the tool to hand-

off patients during shift changes, transferring of patients and as a guide to assist in documenting care following the structured format.

Missing data during the post data collection phase were assessed for missing answers and or incorrect responses to the questions. According to Sylvia and Terhaar (2014), data cleansing is the process of identifying errors in the study and making an adjustment to fix the errors. The author highlighted that this is an important step in data analysis and, if done correctly may increase the quality of the data.

Data Analysis. Data cleansing was performed to assess for missing data and errors after which the IBM SPSS version 25 package was then used to analyze the data. Descriptive statistics were used to describe the sample and both the Z-scores, and p-values were used to compare and calculate pre- and post-survey data findings deriving the mean and average of the pre and post-data. A Z-score is an average of the population. For the post-evaluation questionnaire, descriptive statistics were used to calculate the frequency and percentage of the nurses' perceptions of the SBAR checklist.

Results. Thirty-one participants completed the pre-intervention survey, and for the post-intervention and post-evaluation surveys, thirty participants completed for the final sample. One participant that completed the pre-intervention survey did not participate in the intervention and post-intervention due to role conflict. Calculation of the data was performed using IBM SPSS version 25.0 to generate the Z-score and p-value, mean and the average of each variable. The descriptive statistics for the post-evaluation results were analyzed to assess the frequencies and percentages for each question that is presented in table 5.

Good communication flow exists between members of their function or discipline. The pre-intervention results for question one identified that (86.3%), and for the Post (96.7%), Z -

score/p-value (-1.72; .085) indicated that good communication flow existed between members of their function or discipline. There was no significant finding in the pre- and post-surveys.

Good communication flow exists between members of the interdisciplinary team or other functions. For question two, good communication flow existed between members of the interdisciplinary team or other functions, showed that there was no statistically significant finding in the pre- and post-surveys. Pre (86.7%), post (96.7%), Z- score/p-value (-1.40; .162).

Good communication flow exists between the health care team and patients and families. For question three, good communication flow existed between the health care team and patients and families and revealed that there was a statistically significant finding in the pre- and post-surveys. The Z- score and p-value were used to calculate the difference between the pre (73.3%), post (96.7%), Z -score/p-value (-2.53; .01**) intervention survey. There was valid information to support the findings (figure 1).

Are you familiar with the SBAR tool? For question four, participants response in both pre and post intervention scores were at a 100% indicating that they were familiar with the SBAR tool. Therefore, no calculation was required for the Z- score/p- value since the results were the same.

The SBAR tool will work on your unit*?* The fifth question, will the SBAR tool work on your unit? There was no statistically significant finding in the pre- and post-surveys. Pre (83.3%), Post (90%), Z- score/p-value (-0.76; .447). After the intervention an increase of 6.7% believed the tool would work on the unit.

What do you perceive are the challenges with implementing the SBAR tool? For question six, “What do you perceive are the challenges with implementing the SBAR tool?”,

highlighted the top three challenges identified by the participants in the pre-survey and were arranged in order of their selection as compliance, time to complete, and lack of details and content limitations. The post-survey revealed compliance, lack of time, making the tool a priority and ensuring proper use as the top three challenges.

If the SBAR communication tool was implemented on your unit, would you use it? The responses to question seven regarding using the SBAR communication tool if it was implemented on your unit, showed no statistically significant finding in the pre- and post-surveys. The pre (93.5%), post (100 %), Z- score/p-value (-1.41; .16).

***Post Evaluation*.** The post evaluation revealed that 53% of the participants highlighted that the SBAR facilitated communication between them and other members of the team and patients in positive manner (see table 5). Additionally, 96% of the participants responded "Yes" that they have utilized the SBAR tool in the last 30 days (table 3). When asked how many times they used the tool a valid 66.7% stated 2-5 times (see table 4). 50% of the participants noted that the SBAR checklist helped to remind them of pertinent information to document. Another 50% of the participants felt satisfied that their messages were received and understood by others when utilizing the SBAR tool. 40 % strongly believed that the SBAR checklist reduced the risk for potential risk errors now that it has been introduced.

The results of the observation of the participants using the SBAR checklist revealed an 83.3% correct usage in all four components when delivering the report. The hand-over reports were consistent, and patient focused. Additionally, to support the documentation, the hospital scorecard on chart auditing for both the critical labs and telemetry monitoring documentation remained stable from the pre-implementation to post implementation phase (table 6).

PRE-POST SURVEY SUMMARY

	Agreement* Pre	Agreement* Post	Z-score/ p-value
Q1 Good communication flow exists between members of your function or discipline	83.3	96.7	-1.72; .085
Q2 Good communication flow exists between members of the interdisciplinary team or other functions	86.7	96.7	-1.40; .162
Q3 Good communication flow exists between the health care team and patients and families	73.3	96.7	-2.53; .01**
Q4 Are you familiar with the SBAR tool	100	100	Not calculated
Q5 The SBAR tool will work on your unit	83.3	90	-0.76; .447
Q6 What do you perceive to be the challenges with implementing the SBAR tool	#1 Compliance #2 Time to complete #3 Lack of detail/ content limitations	#1 Compliance #2 Time #3 Making it a priority/ensure proper use	
Q7 If the SBAR communication tool was implemented on your unit would you use it	93.5	100	-1.41; .16

* Agreement = strongly agree + agree
** Post agreement scores significantly higher than pre agreement scores

Table 2.

Table 3: From Post Evaluation Only

Have you used SBAR within the last 30 days?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	30	96.8	100.0	100.0
Missing	System	1	3.2		
Total		31	100.0		

.

Table 4: SBAR Usage

****If yes, how many times have you used SBAR?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Once	2	6.5	6.7	6.7
	2 - 5	20	64.5	66.7	73.3
	6 - 9	3	9.7	10.0	83.3
	10 or greater	5	16.1	16.7	100.0
	Total	30	96.8	100.0	
Missing	System	1	3.2		
Total		31	100.0		

Table 5: Post-evaluation survey

		Count	Column N %
Do you believe there is a reduction in the potential for errors related to communication now that SBAR has been introduced?	Significantly	7	23.3%
	Very much	12	40.0%
	Moderately	5	16.7%
	Slightly	5	16.7%
	Not at all	1	3.3%
Do you feel that the SBAR process was useful in facilitating your communication with other team members or patients?	Significantly	8	26.7%
	Very much	16	53.3%
	Moderately	3	10.0%
	Slightly	3	10.0%
	Not at all	0	0.0%
Do you feel that communication flow between members of your area or discipline has improved since the implementation of SBAR?	Significantly	6	20.0%
	Very much	11	36.7%
	Moderately	10	33.3%
	Slightly	2	6.7%
	Not at all	1	3.3%
Do you feel communication flow between you and your colleagues has improved since the implementation of SBAR?	Significantly	7	23.3%
	Very much	11	36.7%
	Moderately	8	26.7%
	Slightly	3	10.0%
	Not at all	1	3.3%
How satisfied are you that when using SBAR your message is received and understood?	Significantly	10	33.3%
	Very much	15	50.0%
	Moderately	5	16.7%
	Slightly	0	0.0%
	Not at all	0	0.0%
Do you feel that SBAR helps to remind you of important tasks to document?	Significantly	9	50.0%
	Very much	6	33.3%
	Moderately	3	16.7%
	Slightly	0	0.0%
	Not at all	0	0.0%

Table 5.

Documentation of the Use of the Tool:

1) All four steps were completed for most users of the SBAR tool.'
2) Comments noted the need for more structure/focus.
3) Comments noted the tool helped communication during shift change and at times involved the patient.

Table 6. Documentation Compliance

ED Documentation Compliance	Pre -SBAR checklist (Nov)	Post -SBAR checklist (Dec)
Cardiac rhythm	95%	95%
Critical Labs Notification	95%	94.1%

Fig.1

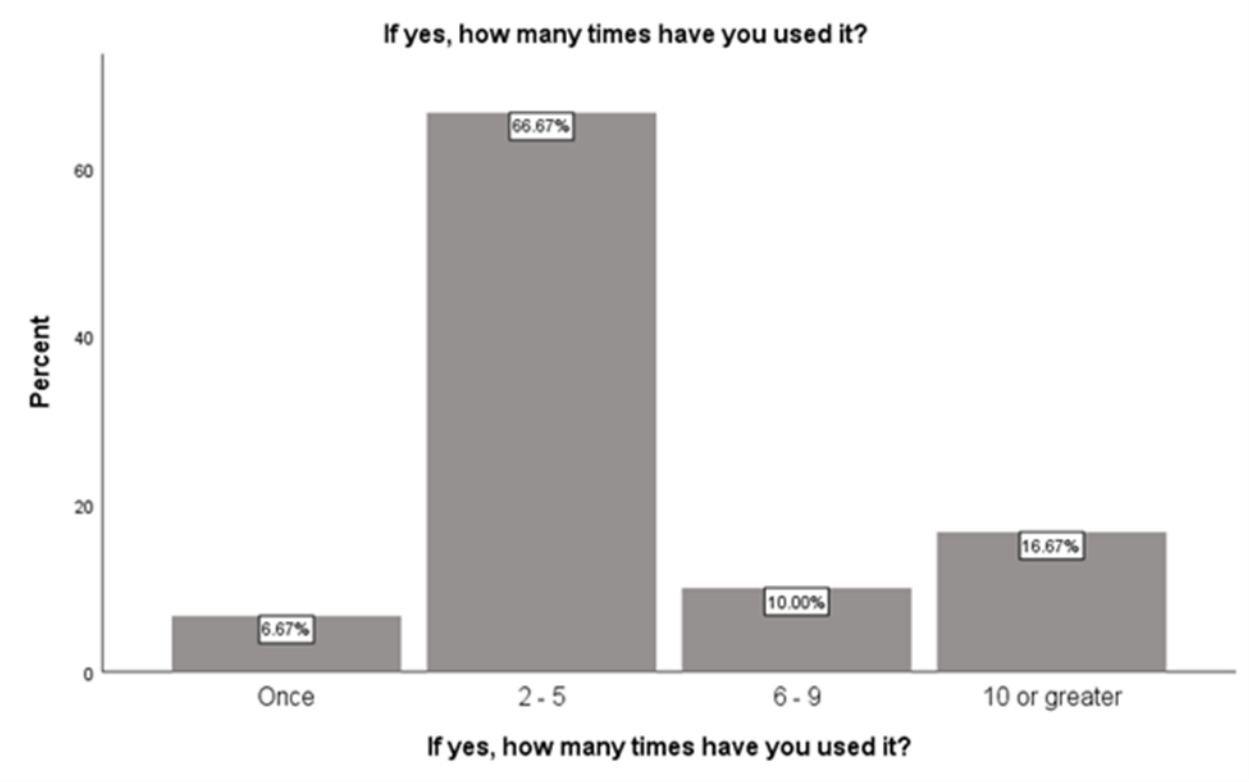
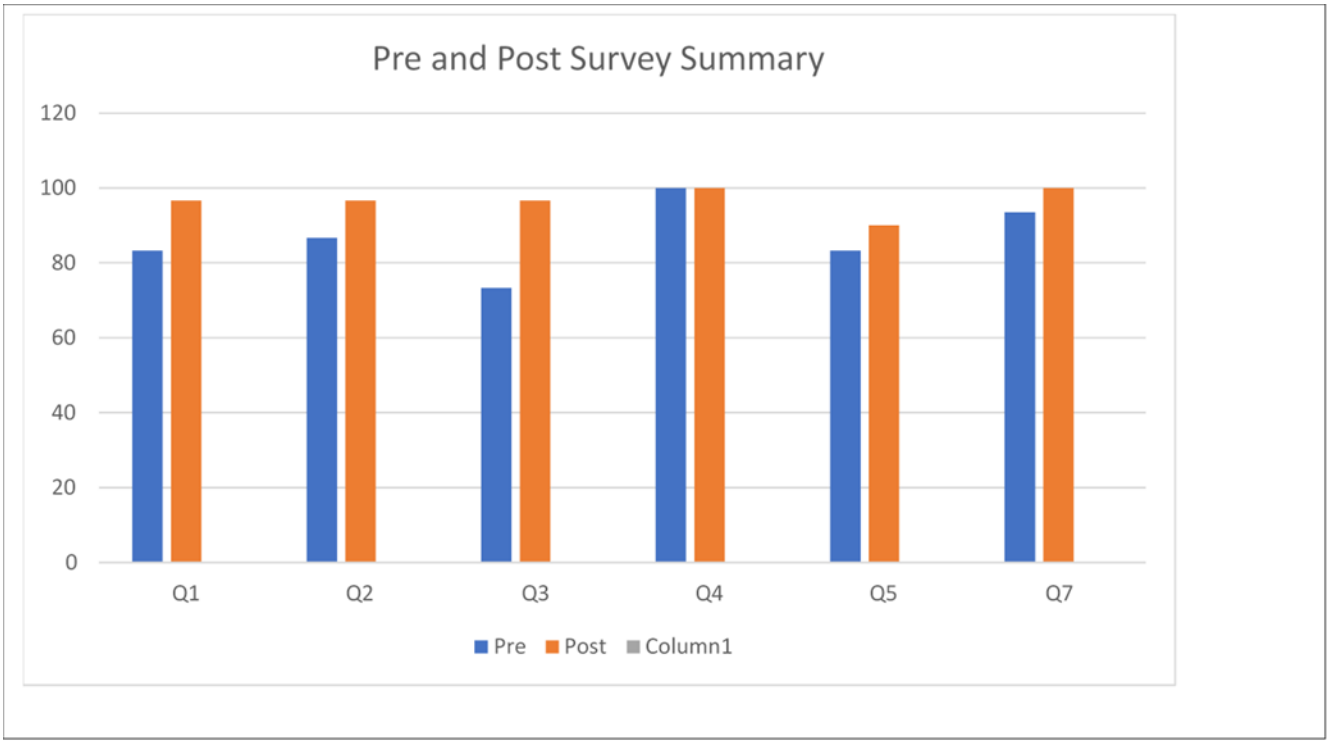


Figure 2



Summary of Sample and Setting Characteristics

Sample. The study participants were recruited from a large convenience sample of 130 Registered Nurses working in the emergency department. The sample was inclusive of nurses working on both days, afternoon, and night shifts. The inclusion criteria were registered nurses working part-time, per-diem and full-time. Excluded from the study were all nurse leaders and float nurses. Of the 130 (N=130) nurses working in the ED, 36 (28%) nurses volunteered to be part of the study (see table 7), 31(24%) participated in the pre -survey and 30 (23%) completed the post-survey. One participant was excluded from the study because of new leadership position.

Setting. The study was conducted in one the most prominent emergency department in the Central Florida region. There were 50 large treatments rooms and approximately 90,000 patients treated in the clinical setting per year (Florida Hospital, 2018). The ED setting offered 24 hours on-call specialized services such cardiac, neurology, trauma, neurosurgery, orthopedics, pediatrics, Internal Medicine, and a state-of-the-art chest pain center to care for patient with heart attack.

ED RN Population	**Number of Participants Volunteered for the study**	**Number Participants in the Pre-study**	**Number of Participants in the post-study**
N=130	N=36 (27%)	N=31(24%)	N = 30(23%)

Table 7. The Emergency Department RN D

Major Findings

One of the major findings of the project result was the significant findings relating to good communication flow that existed between the health care team, patients and families. The data showed that the pre-intervention survey was 73.3% and the post -intervention 96.7% with a

Z-score of -2.53 and p-value of .01**. Substantial evidence from the post evaluation survey supported the findings as evidence by the number of times the participants used the SBAR checklist. Based on the participants' responses, there is a valid 100% usage of the SBAR. 66.7 % of the participants documented that they had utilized the SBAR checklist 2-3 times. Additionally, to support the findings some of the participants comments noted were that the tool benefitted communication during the shift changes and at times involved the patients. 50% of the nurses revealed that they were satisfied that their messages were received and understood, as well as the checklist served as vivid reminder of important information to document.

Although the findings did not completely answer the primary outcome of the PICOT question of improving nurses' documentation and hand-off communication, it however enhanced good communication flow between the healthcare providers and the patient that is vital for creating a safe working environment for both the patient and healthcare providers. The significant finding supported the result found in the literature by Sears and colleagues. According to Nagammal, et al, (2016), the SBAR tool provides healthcare providers with a framework for communicating patients' conditions and has been proven to facilitate the gathering, organization and exchange of information and an effective strategy for improving teamwork.

Kurt Lewin's Theory of Change was important in assisting the staff and the main stakeholders of the clinical setting in understanding the importance and benefits of a planned change. The theory of change motivated their behavior and assisted them in moving in the right direction for achieving positive patients' outcome.

CHAPTER 5: IMPLICATIONS IN PRACTICE AND CONCLUSIONS

Implications for Nursing Practice

Using the SBAR checklist, a structured tool to guide hand-off communications and documentation, has been crucially important in preventing communication errors and its ripple effects. The overall result of the Quality Improvement study supported the literature that the SBAR tool enhances good communication between healthcare providers, patients, and families. Hopefully, the findings of the study will continue to positively impact better patient, provider interaction that will further improve on its positive impact on patient care across the care continuum. Such action will help in fostering a culture of patient safety by reducing the risk of medical errors, delayed care thus promotes an overall improvement patient outcome that yield better satisfaction scores for everyone.

The findings of the study may be utilized by the nurse leaders in the practice setting to reinforce the importance of effective communication and support the success of their chart auditing. The use of the SBAR checklist tool has the potential to help the staff and the organization to bring about positive changes in the work environment and promote cooperative teamwork. The presence of nurse leaders that provide support and feedbacks is crucial for sustaining compliance with the change. Nurse leaders in the department should invest quality time for continuous education, provide feedback on charting and unplanned observation of hand-off communications at the patients' bedside.

More emphasis should be placed on nurses performing hand-off communications at the patients' bedside and documentation in real time. This activity can only strengthen the opportunity for the patients and their families to be involved in their care, foster autonomy and overall make the patient experiences a positive one. Positive patient experiences equate to a

positive working environment and a positive community. According to Anderson, et al, (2014), hand-off communications at the bedside encouraged patients to be involved in their care and has proven to benefit the patients by leaving them reassured when able to participate in shared decision making.

Recommendations

Though the study did not reveal statistically significant changes in the nurses' documentation as set out to be measured, there were significant findings pertaining to patient, provider, and family communications. Based on the findings from the study, 96.7% of the participants post-intervention believed that good communication existed between the provider, patients, and family. The data showed that the pre- intervention survey was 73.3% and the post-intervention 96.7% with a Z-score of -2.53 and p-value of .01**. The result is crucial for both the healthcare organization and nurses in establishing a culture of safety that will be necessary for achieving positive patient outcomes. The findings from the study are vital for both the nurses and their patients since effective and efficient communication is paramount for the safety of the patients, additionally it helps to promote client satisfaction and enhances the work environment for the nurses as well as staff fulfillment. According to Lee, et al, (2016), providing feedbacks and communication about errors enhanced perception of effective hand-off of patient information.

The recommendations are for nurse leaders to demonstrate transformational leadership skills that will encourage continuous support for the use of the structured SBAR checklist. Continuous use of the SBAR checklist will improve communication and possible documentation with time since 50% of the participants stated that the checklist reminded them of important information to chart. Providing authentic positive feedback, incentives for using the tool on a

continuous basis, transparency, and support through motivation as a leader are very helpful in sustaining compliance. Key skill as a leader with transformational leadership skills is the ability to motivate staff, encourage nurse to nurse collaboration and to engage staff in shared decision making that will support buy-in. Other recommendations are for leaders to provide incentives to staff that are actively utilizing the tool for achieving positive outcomes; additionally, more time is needed for the participants to utilize the tool on a more consistent basis. This may allow the staff to get familiar with the tool with the hope that this will increase the proper usage in a more effective manner and may result in a better response on the surveys.

For future research, further study needs to be done to assess the effect of transformational leadership skills for gaining compliance of the SBAR checklist thereby improving nurses' documentation with a longer timeframe for implementation. The number one comment on question 6, what do you perceive to be the challenges with implementing the SBAR was highlighted as compliance in both the pre and the post SBAR assessment questionnaires.

Discussion

Based on the findings of the data analysis, effective communication among healthcare team members is the essence of protecting the safety of the patient. The findings support the literature that good communication flow existed between the health care team, patients, and families. Utilizing a structured tool as a guide to enhance communication, whether written or verbal, is the key to a successful patient-nurse relationship and better patient outcomes. Creating a culture of safety will save time from medical errors issues and increase nurses' job satisfaction. Based on the data analysis a valid 100% of the participants stated they have used the SBAR within the last 30 days. Of that 66.7% expressed that they have used the SBAR checklist 2 to 3 times and 100% expressed that they will used the tool if it is implemented on the unit. Overall,

the SBAR checklist is seen as a promising tool that will help the healthcare team reduce medical errors with continuous use, leadership support, education, motivation, and increased time frame. According to Anderson et.al, (2014), the use of structured communication tools reduces errors of omission and enhance the reliability of information transfer by decreasing the reliance on memory. Although the result of the study did not fully answer the clinical question, there were improvements noted in all areas and particularly the improvements in communication among the healthcare team and patients that is paramount to providing safe patient care. The use of a structured communication tool such as the SBAR checklist should be an integrated part of the nurse's hand-off communication process rather than staff giving a report without a format or guide. This could be helpful in reducing many potential medical errors that can be devastating for both the patient and the nurse and negatively affect productivity. Leadership guidance should be transparent and supportive for sustaining compliance of the tool.

The strength highlighted in the study was the significant findings of improved communication among health care provider, patient and family described in the literature and met one of the project objectives, of improving patient safety. The SBAR tool has been used as a valid tool in many organizations to improve communication.

The weakness of the study is the small sample size used in the study, of the 130 nurses working in the ED only 23% participated in the study. Limitations for the study noted was time constraint, the short time frame of 4 weeks to implement and evaluate the project was a negative factor. Additional time was needed for the proper usage of the tool and for participants to become familiarized with the checklist to offer more opportunities.

Plans for Dissemination.

Dissemination of the findings of the DNP project is an essential aspect of the study that should take place to assist stakeholders for replicating innovation in the practice area to bring about positive changes. The results of the study will aid the staff in the clinical setting develop and improve practice. The findings are geared towards providing evidence-based strategies to help organization improve on their practices and health outcomes (Brown and Crabtree, 2013).

The plan for the project is to share the findings with the nurses and leaders of the Emergency Department to establish pertinent changes. A poster presentation method will be utilized to present the information in a short and concise manner (Forsyth, et al,2010). The presentation will be done during the next staff meeting after which it will be displayed in the staff lounge for others to review. The presentation will include the problem, purpose, result, implication on the practice setting and conclusion.

Plans for publication will be after the completion of the project since the deadline for the journal is momentarily. *The Journal of Nursing Care Quality: The Information Leader in Patient Safety and Quality Care* will be chosen for the publication of the findings of the study. This medium was chosen to publish the findings on the use of the SBAR checklist for improving nurses' documentation and hand-off communications in the ED since the project is geared towards patient safety.

Conclusions and Contributions to the Profession of Nursing

The purpose of the project was to implement and evaluate the effectiveness of a structured, standardized hand off communication tool, the IHI SBAR guideline as a checklist on nurses' documentation and hand-off communications in the emergency department. The use of a PICOT question was developed to assist in guiding the success of the project. Several articles

validated the use of SBAR as a reliable tool that is geared towards achieving effective communication, promoting team collaboration, improving group dynamics, increasing patient safety and staff satisfaction. According to Nagammal, et al, (2016), the SBAR tool provides the healthcare team with a framework for communicating patients conditions, facilitate the gathering, organization and exchange of information and an effective strategy for improving teamwork. Another author, Shahid and Thomas (2018), emphasized the importance of educating the staff on the use of the SBAR so that communication can be understood as well as culture changed to adopt and sustain the structured communication format.

Overall, the findings from the study demonstrated that the SBAR checklist tool continues to play a fundamental part in creating a culture of safety for the patient and with 50% of the nurses being satisfied that their messages were received and understood, as well as serve as a vivid reminder of important information to document. The SBAR tool when used has been effective in improving communication and may serve other areas to improve patient safety but requires the support of leaders and staff for the tool to be effective.

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Appendices, Tables, and Figures

Appendix A: Summary of Primary Research Evidence

Summary of Primary Research Evidence

Citation	Question or Hypothesis	Theoretical Foundation	Research Design (include tools) and Sample Size	Key Findings	Recommendations/ Implications	Level of Evidence
Sears, K., Lewis, S. T., Craddock, M. D. M., Flowers, B. R., & Bovie, L. C. (2014). The evaluation of a communication tool within an acute healthcare organization. *Journal of Hospital Administration*, *3*(5), 79.	Does the SBAR tool improve communication within Lakeridge Hospital?	None	Longitudinal study n=705, SBAR surveys	The tool improved patient safety, by assisting communication with patients and families	Study has shown that the tool is valid for multisite use	Level 3
Nagammal, S., Nashwan, A. J., Nair, S. L., & Susmitha, A. (2016). Nurses' perceptions regarding using the SBAR tool for handoff communication in a tertiary cancer center in Qatar. *Journal of Nursing Education and Practice*, *7*(4), 103.	Nurses' perception regarding the use the SBAR tool for handoff communication	None	Cross sectional, descriptive design, Handover Evaluation Tool (HES) N=102	Provides organized, logical sequence. Improved patient safety Establish communication between nurses and patients	Strongly recommended that SBAR tool deployed in all National Center for Cancer Care and Research	Level 3
Martins, J. C. A., de Sousa, A. C. V., Abrantes, A. R. D., da Silva Pinto, C. S., de Almeida Gomes, C. I.,	What is the evidence on effective team communication and leadership in an emergency situation	None	Met synthesis n=19	Communication should be a two-way, structured (ABCDE, SBAR) process	members should receive regular education and training on communication	Level 1

Martins, D. J. O., ... & Fernandes, M. I. D. (2017). Communication and leadership in emergency situations: Systematic literature review and recommendations for practice. *Clinical Nursing Studies*, *6*(2), 55.						

Appendix B: Summary of Systematic Reviews

Summary of Systematic Reviews (SR)

Citation	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Recommendation/ Implications	Level of Evidence
Holly, C., & Poletick, E. B. (2014**).** A systematic review on the transfer of information during nurse transitions in care	To examine the qualitative evidence on dynamics of knowledge transfer during transitions in care in acute care hospitals.	2 independent reviewers Keywords: Inter-shift handoff, systematic review, transition in care	Critical appraisal instrument, Qualitative studies	125 articles were retrieved, 50 were included in the study	Educating nurses on the proper handoff technique A consistent guideline/framework to guide report. Use of SBAR, Checklist to cue nurses on what to report.	Consistent guideline provides will provide optimal shift report	Level 2
Ransom, B., & Winters, K. (2018). The I-PASS mnemonic and the occurrence of handoff related errors in adult acute care hospitals: a systematic review protocol. *JBI database of systematic reviews and implementation reports*, *16*(1), 21-26.	What is the effectiveness of the I-PASS MNEMONIC in reducing handoff related errors during inter-hospital transfer for hospitalized patients?	Keywords such as errors, mnemonics, handoff, acute care and handover	Acute care hospital for adults and pediatrics of any age who have being hospitalized and is involved in inter /intra hospital transfer	Preliminary study shows that I-PAS has reduced handoff errors but there is no systematic study about how the I-PASS can be used in acute care setting.	I -pass is effective in reducing errors and possible deaths associated with handoff errors.	More systematic review is needed in comparing studies and the effect of I-PASS in the acute care setting.	Level 2
Lee, S. H., Phan, P. H., Dorman, T., Weaver, S. J., & Pronovost, P. J. (2016). Handoffs, safety culture, and practices: evidence from the hospital survey on patient safety culture. *research*, *16*(1), 254.	How different elements of patient safety culture are associated with clinical handoff and perception of patient safety	Handoffs, attitude, patient safety culture, commination, personal responsibility, accountability	Bed size, hospital type, Ownership and staffing were all included in the study	Hospital survey on patient safety culture (HSOSPC) 42 items were used to assess institution patient safety	The main findings were that effective handoff communication, responsibility, accountability was necessary to positive perceptions of patient safety	Training healthcare staff with handoff procedure and protocols can be used to influence a culture of safety.	Level 2
Pucher, P. H., Johnston, M. J., Aggarwal, R., Arora, S., & Darzi, A. (2015). Effectiveness of	Effectiveness of interventions to improve patient handover in surgery	Intervention methods to improve handover information was searched for and	The studies included paper and computerized checklists, proformas, and/or standardized	Of the 19 studies included only 1 study was able to demonstrate compliance in all five	Improvements in information transfer may be achieved through checklist- or proforma-based	future research must be backed by robust study design, relevant outcomes, and clinical implementation	Level 2

Citation	Question	Search Strategy	Inclusion/ Exclusion Criteria	Data Extraction and Analysis	Key Findings	Recommendation/ Implications	Level of Evidence
interventions to improve patient handover in surgery: a systematic review. *Surgery*, *158*(1), 85-95.		identified in several electronic database	operating protocols for handover	areas recommended by JACHO	interventions in surgical handover.	strategies to identify the most effective means to improve information transfer and optimize patient outcomes.	
Shahid, S., & Thomas, S. (2018). Situation, Background, Assessment, Recommendation (SBAR) Communication Tool for Handoff in Health Care–A Narrative Review. *Safety in Health*, *4*(1), 7.	Compare the SBAR communication tool with other tools to assess communication during patient handoff	SBAR, communication, healthcare providers, patient safety	Comparison of another handoff communication tool	This narrative review has highlighted the challenges of communication among health care providers, use of the SBAR tool for effective handoff and transfer of patient care in various health care settings.	The SBAR tool is easy to use and can be modified for other clinical setting	There is a need for future research to assess the impact of a structured SBAR tool on patient-important outcomes and cost-effectiveness of the SBAR tool	Level 1V
Müller, M., Jürgens, J., Redaèlli, M., Klingberg, K., Hautz, W. E., & Stock, S. (2018). Impact of the communication and patient hand-off tool SBAR on patient safety: a systematic review. *BMJ open*, *8*(8), e022202.	To summarize the impact of the implementation of SBAR on patient safety.	Systematic review of articles was performed in several data bases	All original research articles on SBAR fulfilling the following eligibility criteria were included: (1) SBAR was implemented into clinical routine, (2) the investigation of SBAR was the primary objective and (3) at least one patient outcome was reported. Excluded studies with SBAR but no evaluation data on patient outcome	26 different patient outcomes were measured, of which eight were reported to be significantly improved. Eleven were described as improved but no further statistical tests were reported, and six outcomes did not change significantly. Only one study reported a descriptive reduction in patient outcomes.	Moderate evidence for improved patient safety through SBAR implementation, especially when used to structure communication over the phone.	SBAR might be an adaptive tool that is suitable for many healthcare settings, when clear and effective interpersonal communication is required.	Level 2
Colvin, M. O., Eisen, L. A., & Gong, M. N. (2016, February	Improving the Patient Handoff Process in the Intensive Care Unit: Keys to Reducing Errors and Improving Outcomes.	Importance of the Hand off process, review common errors, Identify barriers and strategies	Handoff, handover, patient safety, continuity of care, quality improvement c	Adverse event reduces from 90% to 40% per 1000 patient's days and drug events from 30 to 18 per 1000 patients' days.	Optimization of patient's hand -off becomes critical to improve patient safety	Handoff process may be used to guide patient safety.	Level 11

Appendix C: Project schedule

	NR702								NR705							
Activity	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
Meet with faculty/preceptor	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Conference Call	☐	☒	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐
Midterm Evaluation	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐
Final Evaluation	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☒
Meeting at Practicum site	☐	☐	☒	☒	☒	☒	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐
Needs assessment	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Development of Proposal	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Project Protocol for IRB Approval	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒	☒	☐	☐	☐
Final Planning with Practicum site	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒
Preparation of resources	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒
Preparation of PowerPoint	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒

	NR707								NR709							
Activity	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
Meet with faculty/preceptor	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Conference Call	☐	☒	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐
Midterm Evaluation	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐
Final Evaluation	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐
Presentation of intervention to the staff	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Informed Consent/pre-survey	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Education session	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Implementation of project	☐	☐	☐	☒	☒	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐
Post data collection	☐	☐	☐	☐	☐	☐	☒	☒	☐	☐	☐	☐	☐	☐	☐	☐
Work with Statistician	☐	☐	☐	☒	☐	☐	☐	☒	☒	☒	☒	☒	☐	☐	☐	☐
Writing of Manuscript	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒	☒	☒	☒	☐	☐	☐

Appendix D: SBAR Assessment Tool

Pre and Post questionnaires

Communication questions between functions and disciplines

1. Good communication flow exists between members of your function or discipline?

Strongly Disagree Neutral Agree Strongly Agree Not Applicable

2. Good communication flow exists between members of the interdisciplinary team or other functions?

Strongly Disagree Neutral Agree Strongly Agree Not Applicable

3. Good communication flow exists between the health care team and patients and families?

Strongly Disagree Neutral Agree Strongly Agree Not Applicable

SBAR Questions

4. Are you familiar with the SBAR tool?

Yes (If you answered YES to the above question, please complete the remainder of the survey.)

No

5. The SBAR tool will work on your unit?

Strongly Disagree Neutral Agree Strongly Agree Not Applicable

6. What do you perceive are the challenges with implementing the SBAR tool?

7. If the SBAR communication tool was implemented on your unit would you use it?

Yes

Adapted from Sears et al., (2014). *The Journal of Hospital Administration*

Post- Evaluation Survey

Have you used SBAR within the last 30 days? Yes No

If yes, how many times have you used it? Once 2-5 6-9 10 or greater

2. Do you believe there is a reduction in the potential for errors related to communication now that SBAR has been introduced?

a. Not at all b. Slightly c. Moderately d. Very Much e. Significantly

3. Do you feel that the SBAR process was useful in facilitating your communication with other team members or patients?

a. Not at all b. Slightly c. Moderately d. Very Much e. Significantly

4. Do you feel communication flow between members of your area or discipline has improved since the implementation of SBAR?

a. Not at all b. Slightly c. Moderately d. Very Much e. Significantly

5. Do you feel communication flow between you and your colleagues has improved since the implementation of SBAR?

a. Not at all b. Slightly c. Moderately d. Very Much e. Significantly

6. How satisfied are you that when using SBAR your message is received and understood?

a. Not at all b. Slightly c. Moderately d. Very Much e. Significantly

Adapted from Sears et al., (2014). *The Journal of Hospital Administration*

Appendix E: Permission to use Tool.

Hello Jacqueline,

You have my permission; the original tool was from the Toronto Rehabilitation Hospital. Please let me know if I can be of any assistance. All the best with your work takes care Kim

Kim Sears RN, PhD | Associate Professor
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Adjunct Associate Professor, University of Adelaide, School of Translational Science
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Appendix F: SWOT Analysis

Strength	Weakness
• Organization has an outstanding reputation in the community and is recognized for its work. • Transparent leadership • Available educational resources • Leadership support of the project	• Acuity level of patients • Shortage of nurses • high workload • high patient turnover
Opportunity	Threat
• Improve patient outcome. • Healthy working environment • Increase leadership /staff rapport. • Recruit more nursing staff	• Low staff retention • Medical errors • Low patient satisfaction score

Appendix G: Consent Forms

CONSENT FORM FOR PROJECT PARTICIPATION

Use of the SBAR checklist to Improve Nurse's Documentation in the Emergency Department

Project Leader: Jacqueline Wright-Cole

I am a student at Chamberlain University. I am planning to conduct a quality improvement project study in the Emergency Department which I invite you to take part in. You are being asked to participate in the project about using SBAR checklist to improve nurse's documentation in the ED. The purpose of the study is to improve the quality of nurse's documentation and to create a culture of safety for all the stakeholders involved.

You will be asked to do a pre and post intervention questionnaire on the use of SBAR, attend a 10 mins PowerPoint presentation and to utilize the SBAR checklist during the intervention phase. Your information will be protected and remains confidential. An envelope will be provided for you to seal your information after completion.

Thank you for your participation.

Participant Name _____ Date _____

SBAR: Situation-Background-Assessment-Recommendation

Before filling out the template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

Template: SBAR

S	**Situation:** What is the situation you are calling about? • Identify self, unit, patient, room number. • Briefly state the problem, what is it, when it happened or started, and how severe.	
B	**Background:** Pertinent background information related to the situation could include the following: • The admitting diagnosis and date of admission • List of current medications, allergies, IV fluids, and labs • Most recent vital signs • Lab results: provide the date and time test was done and results of previous tests for comparison • Other clinical information • Code status	
A	**Assessment:** What is the nurse's assessment of the situation?	
R	**Recommendation:** What is the nurse's recommendation or what does he/she want? Examples: • Notification that patient has been admitted • Patient needs to be seen now • Order change	

SBAR Tool adapted from IHI and modified as a checklist **Appendix G.**

ED SBAR Timeline

Situation

S

Patient Name: _____ Admit Date: _____ROOM#: _____ Allergies: _____
Reason: _____
Diagnosis: _____ DNR_____
Admitting Dr.: _____ Consults: _____
Chief Complaint _____
Vital Signs: T: _____ P: _____ R: _____ BP: _____ SaO2: _____ Pain Scale: _____

Background

B

Pertinent Hx:

- DM
- HTN
- CHOL
- AFIB
- ETOH
- DVT
- KIDNEY TX
- LIVER TX
- ANXIETY
- MRSA
- STROKE
- **Baker Act**
- DEPRESSION
- DEMENTIA
- ESRD
- PCKD
- HD/PD
- NEPHRECTOMY
- HEP C
- HEP B
- CIRRHOSIS
- C. DIFF
- VRE
- Cancer
- OTHER_____

WT. _____Kg
Initial Lab Draw _____
I.V. Site _____
I.V. Size _____
I.V. insert: ☐ PTA ☐ ED

Critical Lab Value

☐ WBC ☐ LIVER
☐ LYTES ☐ RENAL
☐ H & H ☐ Troponin
☐ GLUCOSE ☐ MRSA/VRE
☐ OTHER _____ ☐ Lactic Acid

Assessment

A

Neuro
A&O x1 x2 x3 confused forgetful
Up Ad Lib Assist x1 x2 Complete
Stroke Protocol

Respiratory
O_2: RA NC ___L
IS Measurement:
CLEAR DIMINISHED RHONCHI
CRACKLES

Cardiovascular
Rhythm: SR SB ST AFIB PACED
PVCs
VAD - RT/LT
Edema: +1 +2 +3 +4

GI
Flatus: YES / NO
BM: YES / NO Last _____
Colostomy: Yes /No
Emesis: YES / NO

GU
Voids Incontinent Brief
Bedpan
AV Fistula : LUA RUA

Foley
Insert Date: ____
Last Peri Care: _____

Skin/Incision/Wound
Areas of skin breakdown?
Wound Vac Settings:
Dressing Changes Ordered?

Protocol Yes/No

Falls Risk Yes/No

Psychosocial

Family member present *Y/N*

Spiritual Needs /Cultural Y/N

Reassessment

Recommendation

R

Plan of Care: _____

Orders: _____

Ongoing Nurse: Any questions _____

TO DO LIST

IV Management
Type: _____
Current Rate: _____
Med Drips
Antibiotics
Time started
Blood Transfusion
___/___/ _____

MAR

Notes

Appendix G

July 12, 2018

Chamberlain College of Nursing

DNP Faculty

3005 Highland Parkway

Downers Grove, IL 60515

To whom it may concern,

Please accept this letter of support from the Emergency Department for Mrs. Jacqueline Wright-Cole to implement evidence- based strategies to assist in improving nurse's documentation of care in the Emergency Department. It is our expectation that because of these interventions our nurses will demonstrate an improvement with compliance with best practice standards for real time documentation, enhance high quality patient care, ensure patient safety, as well as create an exceptional patient experience.

Sincerely,

Emergency Department Manager

Nurse Educator

Appendix H: Plan for Educational Offering

Plan for Educational Offering

OBJECTIVES	**CONTENT (Topics)**	**TEACHING METHODS**	**TIMEFRAME**	**EVALUATION METHOD**
At the end of the teaching session the leaner should be able to (1) Define SBAR (2) describe the purpose of the SBAR tool, (3) identify the SBAR components	*Content to be covered include definition of the SBAR, purpose, Components of the SBAR and details of each*	*A PowerPoint presentation on the topic will be given along with a case study scenario to help with the understanding of the content*	*Two minutes will be given for each objective*	*Question and answer session to assess the learner's knowledge.*

Tables

Table 1: Project Budget

Resources Needed	Cost	Amount	Total
Office supplies	$500		$500
Printing of handouts	$500		$500
Food for Training	$250	2 shifts (day& night)	$500
Statistician	$505		$505
Total Expenses			$2005

Table 2: Pre and Post Survey Summary

PRE-POST SURVEY SUMMARY

	Agreement* Pre	Agreement* Post	Z-score/ p-value
Q1 Good communication flow exists between members of your function or discipline	83.3	96.7	-1.72; .085
Q2 Good communication flow exists between members of the interdisciplinary team or other functions	86.7	96.7	-1.40; .162
Q3 Good communication flow exists between the health care team and patients and families	73.3	96.7	-2.53; .01**
Q4 Are you familiar with the SBAR tool	100	100	Not calculated
Q5 The SBAR tool will work on your unit	83.3	90	-0.76; .447
Q6 What do you perceive to be the challenges with implementing the SBAR tool	#1 Compliance #2 Time to complete #3 Lack of detail/ content limitations	#1 Compliance #2 Time #3 Making it a priority/ensure proper use	
Q7 If the SBAR communication tool was implemented on your unit would you use it	93.5	100	-1.41; .16

* Agreement = strongly agree + agree
** Post agreement scores significantly higher than pre agreement scores

Table 3: From Post Evaluation Only

Have you used SBAR within the last 30 days?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	30	96.8	100.0	100.0
Missing	System	1	3.2		
Total		31	100.0		

Table 3.This table highlights question 1 on the post evulauation survey.

Table 4: SBAR Usage

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Once	2	6.5	6.7	6.7
	2 - 5	20	64.5	66.7	73.3
	6 - 9	3	9.7	10.0	83.3
	10 or greater	5	16.1	16.7	100.0
	Total	30	96.8	100.0	
Missing	System	1	3.2		
Total		31	100.0		

Table 4. This table highlights the follow up response from question 1.

Do you believe there is a reduction in the potential for errors related to communication now that SBAR has been introduced?	Significantly	7	23.3%
	Very much	12	40.0%
	Moderately	5	16.7%
	Slightly	5	16.7%
	Not at all	1	3.3%
Do you feel that the SBAR process was useful in facilitating your communication with other team members or patients?	Significantly	8	26.7%
	Very much	16	53.3%
	Moderately	3	10.0%
	Slightly	3	10.0%
	Not at all	0	0.0%
Do you feel that communication flow between members of your area or discipline has improved since the implementation of SBAR?	Significantly	6	20.0%
	Very much	11	36.7%
	Moderately	10	33.3%
	Slightly	2	6.7%
	Not at all	1	3.3%
Do you feel communication flow between you and your colleagues has improved since the implementation of SBAR?	Significantly	7	23.3%
	Very much	11	36.7%
	Moderately	8	26.7%
	Slightly	3	10.0%
	Not at all	1	3.3%
How satisfied are you that when using SBAR your message is received and understood?	Significantly	10	33.3%
	Very much	15	50.0%
	Moderately	5	16.7%
	Slightly	0	0.0%
	Not at all	0	0.0%
Do you feel that SBAR helps to remind you of important tasks to document?	Significantly	9	50.0%
	Very much	6	33.3%
	Moderately	3	16.7%
	Slightly	0	0.0%
	Not at all	0	0.0%

Table 5. This table highlights the result of the post evaluation survey

Documentation of the Use of the Tool:

1) All four steps were completed for almost all users of the SBAR tool.'
2) Comments noted the need for more structure/focus.
3) Comments noted the tool helped communication during shift change and at times involved the patient

Table 6: Hospital Documentation Compliance

ED Documentation compliance	Pre-checklist Intervention	Post -checklist Intervention
Cardiac rhythm	95%	95%
Critical labs	95%	94.1%

This table highlights the two critical components audited monthly by the ED.

Table 7: ED Nurses Demographics

ED RN Population	Number of Participants Volunteered for the study	Number Participants in the Pre-study	Number of Participants in the post-study
N=130	N=36 (27%)	N=31(24%)	N = 30(23%)

Figures 1: Pre and Post SBAR Assessment Survey Summary

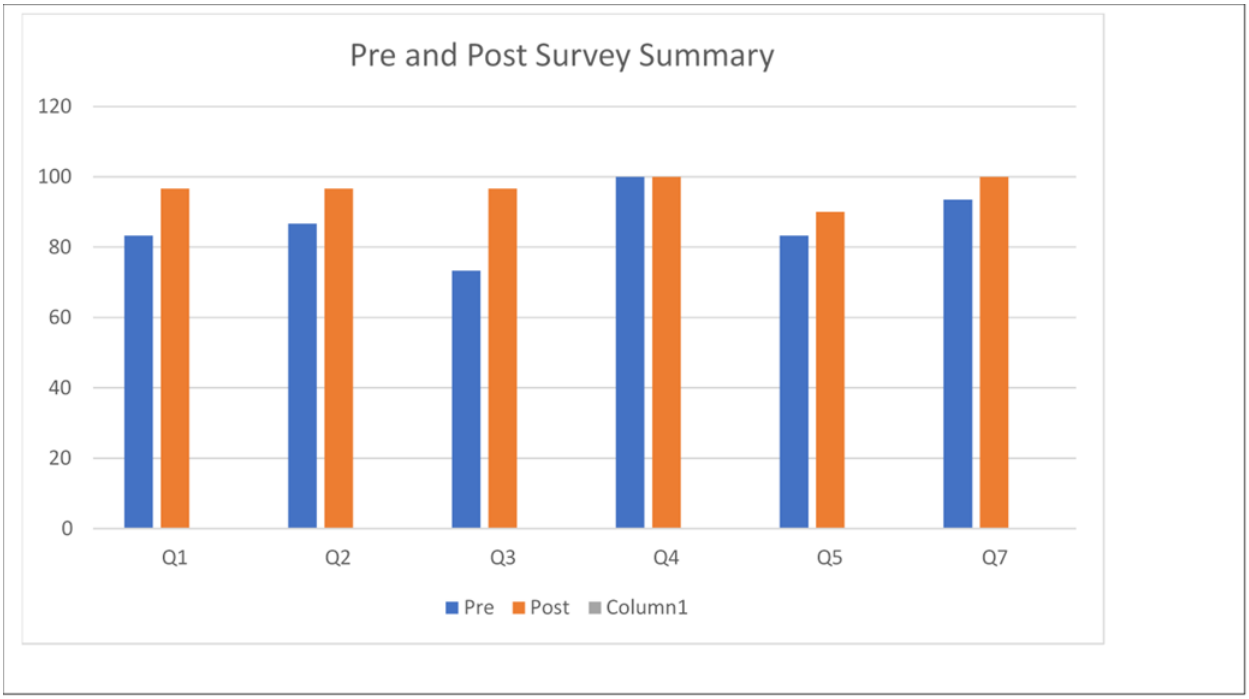

Figure 2: Significant Finding on Post- evaluation Survey.