EXPLORING THE PROCESS OF IMPLEMENTING NURSING BEDSIDE SHIFT REPORT

by

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The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, a thesis entitled:

Exploring the Process of Implementing Nursing Bedside Shift Report

Submitted by Kimberly Brownjohn in partial fulfillment of the requirements for the degree Master of Science in Nursing

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Abstract

Patient-and-family-centred care is at the forefront of today's health care. Conducting shift report at the bedside is one patient-and-family-centred nursing practice being implemented at health care institutions. A review of the literature revealed that few studies have explored the process of implementing bedside shift report (BSR) at various health care institutions; most reports focus on the experiences of single units or single institutions. The purpose of this study is to explore what can be learned about optimizing the implementation of bedside shift report from the perspective of nurses who have implemented it. An interpretive description methodology guided semi-structured interviews with nine nurses recruited from four Canadian hospitals. The analytic process revealed two main themes and corresponding sub-themes (a) Strategies for implementation (creating a BSR implementation working group, group member preparation, creating staff awareness, staff education sessions and the initiation of BSR) and (b) BSR implementation challenges (attitudes and beliefs about BSR, dissemination of patient information and confidentiality concerns, the impact of changing practice to BSR, and nurses' negative influence on BSR). Nurses resisted the implementation of BSR because it interfered with the communication style of current handover practices, the social time that occurs with current practices and the valuable time to debrief with colleagues. Furthermore, nurses opposed BSR due to the need to report objectively, be more accountable and portray professionalism. In addition, practicing BSR is impeded by naysayers, bullying, peer pressure and the presence of stymied culture. The findings suggest the need to determine the appropriate methods for implementing BSR as well as including education on communication and bullying. Further research exploring the meaning of nursing handover, nursing perspectives on relational

dynamics in nursing and the impact on practice environments may provide information to assist with the implementation of BSR.

Lay Summary

Bedside shift report (BSR) is a patient-and-family-centred care nursing practice increasingly being implemented by health care institutions. The purpose of this study was to explore what can be learned about optimizing the implementation of bedside shift report from the perspective of nurses who have implemented it with the intent to add to our understanding of the successes and challenges of this implementation process. Nine nurses were interviewed from four different health care institutions in Canada. The findings revealed that resistance to BSR occurred due to the interruption of familiar practice norms such as communication style, and complications related to relational dynamics in nursing such as bullying and the presence of stymied culture. Recommendations based on the study findings included assessing the nursing environment to ensure appropriate implementation methods and incorporating education on communication within in BSR education sessions.

Preface

This thesis represents the original unpublished work by the author Kimberly Brownjohn. Under the guidance of my supervisor, Dr. Sally Thorne, and committee members Dr. Martha Mackay and Dr. Maura MacPhee, I completed all aspects of this research. This study received approval from the UBC Research Ethics Board (Certificate # H17-00425). To date no part of this thesis has been published.

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List of Abbreviations

AHRQ	Agency for Healthcare Research and Quality
BREB	Behavioural Research Ethics Board
BSR	Bedside shift report
CFHI	Canadian Foundation for Healthcare Improvement
CINAHL	Cumulative Index to Nursing and Allied Health Literature
EBP	Evidence-based practice
IPFCC	Institute for Patient and Family Centered Care
PFCC	Patient-and family-centred care
PHC REB	Providence Health Care Research Ethics Board
SOPs	Standardized operating protocols
UBC	University of British Columbia
WHO	World Health Organization

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CHAPTER ONE: INTRODUCTION

Background to the Problem

Patient-and family-centred care (PFCC) is at the forefront of today's health care. Health care practice is changing from health care professional dominated care to care centred more around patients and their families. Many health care institutions are changing practice to adopt a model of PFCC. Nurses have a significant role in patient care and, therefore, play an integral part in adopting patient-and family-centred health care practices. Conducting shift report at the bedside is one practice change implemented by nurses that is part of a PFCC model. Commonly, nursing shift report is conducted away from the bedside without patient and family involvement. Since nursing bedside shift report (BSR) is increasingly being implemented by health care institutions, further research is needed to determine the most effective way to implement this change in nursing practice. Such research may contribute to the practice of BSR by identifying some of the common successes and challenges encountered in this nursing practice change.

Patient-and Family-Centred Care

PFCC has been gaining prominence in world health systems. In 2007, the World Health Organization (WHO) introduced a policy framework called "People-Centred Health Care." This document was introduced to encourage governments to change their health care delivery to include a more patient-centred approach in accordance with the public's expectations. The WHO described the potential benefit of a PFCC model as "increased patient safety, improved adherence to care plans, improved treatment and health outcomes, increased satisfaction with care and improved quality of life for patients and their families, the community and society at large" (p. 14).

The Institute for Patient and Family Centered Care (IPFCC) (2010) defined PFCC as "an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients and families" (par. 1). Therefore, PFCC is not only about patients and families participating in their health care decision-making, but also involves including patients and families in government policy making, program development and evaluation of health care (IPFCC, 2010). PFCC is an approach to care that is being incorporated in various areas of health care around the world, including Canada.

The patient-and family-centred care model is not a new approach to health care in Canada. According to the Canadian Foundation for Healthcare Improvement (CFHI), Saskatchewan was the first province in Canada to introduce this notion in the "Patient First Review" in 2008 (2014, p. 13). This review included recommendations that were considered patient and family centred, as they focused on gathering information from patients about their perspectives and experiences with the health care system. The recommendations stemming from this review led to changes in the Saskatchewan health care system. In 2014, the CFHI put out a document that included PFCC as a primary area of focus for healthcare in Canada. In February 2015, the British Columbia Ministry of Health named "The British Columbia Patient-Centred Care Framework" as the number one priority in its strategic plan. The Ministry document introduced a framework for patient centred care to be adopted by members of the British Columbia health care system. This document included a definition of "Patient Centred Care", the "Vision", "Core Principles," and "Patient-centred Care Practices" expected to be integrated by members of the British Columbia health care system (British Columbia Ministry of Health, 2015).

According to IPFCC (2010), applying a patient-and family-centred care model means incorporating the main concepts of PFCC which include, "respect and dignity," "information sharing," "participation," and "collaboration" (par. 2). PFCC practices can be adopted by health care institutions in a variety of ways, and many of these changes involve improved communication with patients and families. According to the IPFCC, open visiting hours, patient and family involvement in rounds, family presence during procedures and resuscitation, and conducting nurse handover at the bedside are some of the practices considered to be PFCC.

In recent years, a Vancouver hospital incorporated a patient-and family-centred care model into its strategic plan. These changes included the implementation of a help line called "Code H" for inpatients and families to call if there are unaddressed concerns with the medical status or plan of care; a "Family Presence Policy," which included open visiting hours and family presence as the patient desires; a "Professional Image Policy" to ensure staff could be clearly recognized; and the development of a committee called the "Care Experience Strategic Direction Advisory Committee" made up of patients, family members and staff with a focus on patient and family centred care (Providence Health Care, 2016). Subsequently, nursing BSR was introduced at this hospital as the next step in the development of a comprehensive patient-and family-centred care approach.

Nursing Bedside Shift Report

In 2007, the WHO identified that changes should be made in the way health care providers relay patient information, to reduce communication gaps. The WHO explained that "these gaps in communication can cause serious breakdowns in the continuity of care, inappropriate treatment and potential harm to the patient" (p. 1). Therefore, the WHO recognized that involving patients and their families during shift report could create the

conditions under which continuity could be maintained, thereby enhancing patient care and safety. Furthermore, in 2012, the American Nurses Association identified "an estimated 80 percent of serious medical errors involve miscommunication between caregivers when patients are transferred or handed off" (par. 1). Accurate communication of patient information between health care providers is essential for maintaining patient safety and quality patient care.

Nurses most often exchange patient information at change of shift and when transferring a patient to a different area of care. This exchange of information is often identified as "shift report" if it is at the end of a shift and "handover" if it is conducted after the transfer of a patient. This report can occur several times in a twenty-four hour period and commonly includes the reason for the patient's hospitalization, medical history, most recent medical status, test results, current medications and plan of care. This exchange of information has routinely been done away from the patient's bedside without patient and family involvement.

The common practice of conducting nursing shift report away from the bedside is slowly evolving to the bedside to include patients and their families. Griffin (2010) explained that BSR is in keeping with PFCC because it "offers an opportunity to improve the patient experience of care by partnering with patients and families" (p. 349). Several studies have reported that BSR increased patient involvement in care, keeps patients and families informed about patients' plan of care and increases patients' overall satisfaction with care (Cairns, Dudjak, Hoffman & Lorenz, 2013; Gregory, Tan, Tilrico, Edwardson & Gamm 2014; Jeffs et al., 2014; Kerr, Mckay, Klim, Kelly & McCann, 2013; Sherman, Sand-Jecklin and Johnson, 2013; Tobiano, Chaboyer & McMurray, 2012).

Problem Statement

Since PFCC has been identified as a priority for the British Columbia health care system and BSR is a nursing practice change identified as patient-and family-centred, I anticipate more health care institutions will be adopting this change in nursing practice. To my knowledge, only a small number of Canadian hospitals practice shift report at the bedside. Notably, BSR is done in a pediatric hospital in Vancouver, British Columbia, and in hospitals in Edmonton, Alberta, and Toronto, Ontario. Based on my literature review, I believe that few studies have explored the various processes of implementing BSR at different health care institutions. The successes and challenges faced with this practical change need to be more clearly examined and understood. Potentially, this information could assist nursing leaders with implementing this change in practice.

Research Purpose

The purpose of this study is to add to our understanding of successes and challenges in the process of implementing BSR. The intention is that nursing leaders may be able to use this knowledge to assist in the implementation of nursing bedside report as a component of patient-and family-centred care.

Research Question

The primary research question to be answered by this study is: What can be learned about optimizing the implementation of bedside shift report from the perception of nurses who have implemented it?

Structure of the Thesis

This chapter has introduced the research problem to be considered in the study. Chapter two provides a review of the relevant literature in relation to the field of bedside shift reporting in nursing practice. Chapter three describes the methodology for the study and the approach that will be used to answer the research question. Chapter four presents the findings on the basis of the data collected and analyzed. And finally, chapter five provides a discussion of the findings, considers the implications and limitations of the study, and draws conclusions.

CHAPTER TWO: LITERATURE REVIEW

Literature Review Criteria and Search Strategy

A comprehensive search of the literature was conducted using predetermined criteria. The literature search focused on finding mainly primary research articles; however, opinion and discussion based articles were reviewed to gain a more comprehensive overview of the current literature on the process of implementing BSR (Polit & Beck, 2012). The research articles included in this literature review were published within the past 10 years with the exception of including articles over 10 years if they were highly relevant to the research question. Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE and PubMed were the online databases used for the literature search. The key terms used to search through the databases were *nursing bedside handover, nursing bedside shift report,* and *nursing bedside handoff.* These terms were also combined with *patient-centred care* or *patient safety.* Furthermore, the reference lists from primary articles were reviewed to identify additional literature relevant to the research study. Fifteen of the thirty-five articles identified were included in this literature review. A majority of the articles found with this literature search were excluded from this review if there was no discussion on the BSR implementation process or identification of challenges and successes associated with the process.

The Literature Review

Nursing Bedside Shift Report

As previously discussed, nurses in Canada have traditionally conducted shift report away from the bedside; however, nursing practice is changing to be more inclusive of patients and families. According to Anderson and Mangino (2006), "as patients become more knowledgeable

consumers of healthcare, they understand that they have certain rights and desire more education and knowledge" (p. 113). Patients' and families' requests for more information and participation in their medical care has motivated health care professionals to improve how they provide care. Since BSR has been identified as a patient-and family-centred nursing practice, there has been an increase in the implementation of BSR in North American hospitals (IPFCC, 2010). Researchers have also attributed other motivations for this change in practice to a dissatisfaction with report processes and a means to increase patient safety (Bradley & Mott, 2013; Chaboyer et al., 2009; Evans, Grunawalt, McClish, Wood, & Friese, 2012; Jeffs et al., 2013; McMurray, Chaboyer, Wallis, & Fetherston, 2010; Thomas & Donohue-Porter, 2012). Further motivation for this change in practice is that the literature demonstrated BSR was viewed positively by patients and nurses after it was implemented. In recognition of the increased rate of implementation of BSR in Canadian hospitals and my current experience with the implementation of BSR, this study will focus on learning from health care professionals about the process of implementing BSR. In this chapter, I will discuss the reported patient and nurse perceptions of BSR and the suggested challenges and potential strategies for implementing BSR as identified in the current literature.

Commonly Identified Perceptions of BSR

My review of the current literature indicates that several authors have reported on both patient and nurse perceptions of BSR. A large number of authors have reported that patients (Anderson & Mangino, 2006; Bradley et al., 2013; Jeffs et al., 2014; Kassean & Jagoo, 2005) and nurses (Bradley et al., 2013; Cairns et al., 2013; Evans et al., 2012) perceived BSR positively. In an Australian study that looked at the outcomes of changing nurse handover to BSR as part of a quality improvement project, the researchers reported that patients believed BSR kept them better informed about their care while in the hospital (Chaboyer et al., 2009). In

a Canadian study exploring patients' perceptions of BSR, Jeffs et al. (2014) interviewed 45 patients and found that, although patients preferred different amounts of information sharing, they generally believed BSR was beneficial. In another Australian study, Bradley et al. (2013) interviewed 9 patients from 3 different rural hospitals where BSR had been implemented, and reported that all patients believed BSR allowed them to be included in their care and kept them informed about their care.

One assumption prominent in the literature is the idea that BSR enhances shared decision making, due to the increased communication and information access that patients have relevant to their care. To date, I have located only one study that sought to measure whether BSR improved patients' perceptions of decision making. Based on a survey of cardiac surgery patients before and after implementation of BSR, German researcher Koberich (2014) was unable to detect a statistically significant difference in patients' perceptions of being involved in decision making with BSR, as compared to the previous shift report practice. However, these measures could have been due to the quality of patient-centered care previously practiced on this cardiac surgery unit. With the exception of this study, most authors who have examined this question have reported that patients believed BSR had positive aspects and improved the care they received.

Positive nurse perceptions were also commonly reported in the literature on BSR. In a survey conducted with nursing staff working on a 32-bed general surgical unit in an American hospital, Anderson and Mangino (2006) found that BSR increased nurses' satisfaction with "accountability, interpersonal relationships, and receiving pertinent information" (p. 117). Similarly, in a survey conducted with 18 nurses three months after the implementation of BSR on a trauma unit in an American hospital, Cairns et al. (2013) found nurses believed patient

handover was "concise and contained information more pertinent to the patients' condition" (p. 163). Although many of the studies aimed at evaluating the impact of BSR have used patient and nurse perceptions as an outcome measure, some researchers found that BSR also produced changes affecting practice, including decreased call light usage during shift change, nurse overtime and length of report time (Anderson & Mangino; Cairns et al.; and Evans et al.).

The Process of Implementing BSR

Generally, BSR has been viewed as a favourable practice by nurses and patients. Many of the studies conducted on BSR reported on the outcomes of implementation and provided only a brief description of the process used for implementation of BSR. While as of yet there are a limited number of published reports on the implementation process of BSR, the literature reveals some challenges and potential strategies for successful implementation.

Challenges identified with implementing BSR.

The most common challenges reported in the literature include confidentiality concerns, staff resistance and concerns with sustaining BSR. The concern for confidentiality has been frequently noted in the literature (Anderson, Malone, Shanahan & Manning, 2014; Cairns et al., 2013; Chaboyer et al., 2009; Evans et al., 2012; Jeffs et al., 2013; Kassean et al., 2005; and Thomas & Donohue-Porter, 2012). In a recent literature review by Anderson et al. of support for implementing BSR over other clinical handovers, confidentiality was identified as a concern by nurses when conducting report at the bedside. According to the authors, this concern for patient privacy, "contributes to poor communication between staff and the exclusion of the patient in participating in decision making about their care" (p. 669). McMurray et al. (2010) also reported that the nurses interviewed in their study often mentioned their concerns regarding patient

confidentiality; however, the researchers found these concerns lessened as nurses became more experienced with BSR.

Staff resistance to the implementation of BSR was another challenge mentioned in the literature. In a study conducted by Jeffs et al. (2013), on the *Enablers and Barriers to Implementing Bedside Reporting,* resistance to the BSR practice change was a common theme that came out of the 43 semi-structured nurse interviews. Jeffs et al. explained that resistance occurred due to "preconceived beliefs about nurse-to-nurse bedside reporting not being a better way to exchange information" (p. 47). Similarly, a number of authors explained that nurses resisted the change to BSR due to their predetermined ideas about BSR (Anderson & Mangino, 2006; Kassean et al., 2005; McMurray et al., 2010; Radtke, 2013; Thomas & Donohue-Porter, 2012; Wakefield et al., 2012). Thomas and Donohue-Porter also found that this resistance to the implementation of BSR was due to nurses' negative views. According to the authors, different methods and communication strategies were used to change these views. The change in nurses' views was reflected in a post-implementation survey that confirmed increased satisfaction with BSR versus the past reporting method. However, resistance to BSR was frequently mentioned in the literature as a challenge that was possible to overcome.

Sustaining BSR was another commonly identified challenge. After implementing BSR on a trauma unit in an American hospital, Cairns et al. (2013) found that it was difficult to sustain this practice. The authors described a situation where some nurses went back to their previous method of reporting away from the bedside. According to Cairns et al., this behaviour was corrected by having leadership present to monitor BSR. Similarly, Radtke (2013) also concluded that in order for BSR to be a successful practice change, leadership members needed to maintain their involvement in the process and establish "clear expectations and intervention"

to ensure BSR was sustained (p. 25). Moreover, to help sustain the practice of BSR, Chaboyer et al. (2009) included BSR as a nursing competency and in annual performance reviews. Although authors did not focus specifically on the topic of sustaining BSR, it was frequently mentioned in the literature along with suggested solutions.

Potential strategies for implementing BSR.

Authors have identified proper planning as the key to successful implementation of BSR. The literature revealed that commonly, hospital standardized operating protocols (SOPs) or guidelines were developed prior to implementing BSR (Agency for Healthcare Research & Quality, 2013; Chaboyer et al., 2009; Evans et al., 2012; Kassean et al., 2005; McMurray et al., 2010; and Thomas & Donohue-Porter, 2012). Chaboyer et al. explained that, for their quality improvement project, a group of experts developed guidelines as a formal reference for nurses to follow when conducting BSR. Similarly, Evans et al. stated that guidelines were developed for a BSR pilot project, and later a SOP was implemented for BSR on a 32 bed medical/surgical unit in an American hospital. The authors described that the SOP "outlined responsibilities of nursing staff in facilitating and conducting nurse-to-nurse shift report at the patient bedside" (p. 283). Furthermore, in an Australian study by McMurray et al., researchers sought to identify factors influencing the change process from reporting away from the bedside to practicing BSR. Researchers interviewed 34 nurses from medical, surgical and rehabilitation wards and found that it was important for nurses to have standardized guidelines for BSR as the nurses "believed that systematising the information transfer enhanced their confidence in its appropriateness" and maintained consistent care (p. 2585).

Formal education and training for conducting BSR were also frequently identified as part of the implementation process. In a review of the challenges and rewards of implementing BSR

on a surgical unit, Anderson and Mangino (2006) identified that formally educating the nursing staff prior to implementing BSR was part of the structured approach. Similarly, in a study conducted on the effectiveness of BSR, Cairns et al. (2013) explained that nurses were provided education on BSR that included the "benefits, goals, report-process guidelines and measures of success" (p. 162). The Agency for Healthcare Research and Quality (AHRQ) (2013) developed a staff training manual for the implementation of BSR titled "Nurse Bedside Shift Report: Implementation Handbook." The AHRQ recommends training staff prior to implementing BSR and includes different training strategies in the BSR handbook (p. 10). The current literature demonstrates that formal education is often provided to nurses prior to the implementation of BSR.

Some authors have noted that including nursing staff in the process of implementing BSR by assessing staff concerns prior to implementation is also effective (Anderson & Mangino, 2006; Cairns et al., 2013; Chaboyer et al., 2009; McMurray et al., 2010; Thomas & Donohue-Porter, 2012 & Wakefield, Ragan, Brandt & Tregnago, 2012). McMurray et al. found that collecting data from nursing staff on the previous shift report method prior to implementing BSR assisted in the change process, as nurses identified they were not satisfied with their current reporting process. The authors argued that the dissatisfaction with the current report process meant more willingness to change. In an American study on a medical/surgical unit looking at the transition to BSR before and after implementation, Wakefield et al. claimed that collecting data from nurses prior to implementing BSR helped anticipate the potential barriers and facilitators for this change in practice. In order to decrease the likelihood of staff resistance to the change, the authors obtained approval for the change to BSR from the unit's "Nursing Shared Governance Council" (Wakefield et al., p. 249). According to Wakefield et al., support from the

council provided more support for the practice change. These findings indicate that success is more likely if nurses are involved in the implementation process.

Additionally, engagement of leaders was identified in the literature as a way to help with the success of implementing BSR as well as sustaining the practice. Leaders' engagement was described as the involvement of patient care leaders and clinical nurse leaders in the process of implementing BSR. Radtke (2013) conducted a study on a medical/surgical ward to determine if implementing BSR improved patient satisfaction. Radtke explained that to help with the success of implementing BSR, leaders needed to be engaged by "mentoring staff and assisting with initiative rollout, coaching staff through this change in practice, and reinforcing this change as an expectation of practice" (p. 23). After implementing BSR on medical/surgical units in seven American hospitals, Thomas and Donahue-Porter (2012) determined that involving and educating leadership on BSR was necessary as leadership presence during the implementation process ensured staff support. Furthermore, Cairns et al. (2013) found that "routine observation and individual feedback by the unit director" was helpful when nurses began to revert back to reporting away from the bedside (p. 163).

Summary of the Literature Review

The literature on the implementation of BSR is not vast and the majority of the experiences reported on the implementation of BSR focus solely on the experience of a single unit or hospital. Nonetheless, the findings from this literature review indicate that health care professionals are experiencing some common successes and challenges with the implementation process. Despite these findings, further research is needed to determine the most effective way to implement BSR. To my knowledge, there are no published studies exploring health care professionals' experiences with implementing BSR at various health care institutions. Since the

available literature focuses primarily on the experiences of single units or institutions, I hope to help fill the gap in the literature by exploring health care professionals' experiences of implementing BSR at a variety of institutions across Canada. I anticipate that having the ability to consider the implications of the variations between settings will contribute to establishing how to plan for the most effective way to implement BSR. Examining this implementation process, across multiple contexts, will yield new insights that may help us to ensure sustainability of this patient-centred practice.

CHAPTER THREE: RESEARCH METHODS

Methodology

This study was guided by interpretive description. Interpretive description is a qualitative methodological framework originally developed by Thorne, Kirkham and MacDonald-Emes (1997) for the applied sciences. The interpretive description methodology is different from traditional qualitative methodologies as it was created for the purpose of applying newly developed knowledge to clinical practice rather than focusing solely on theorizing (Thorne et al., 1997; Thorne, 2016). Interpretive description was selected to guide this study not only for its pragmatic approach but also to build upon "what is already 'known'" about the implementation of BSR and to use this knowledge to "enhance" nursing practice (Thorne, 2016, p. 49).

Interpretive description was the most suitable methodology for this study because "it offers the potential to deconstruct the angle of vision upon which prior knowledge has been erected and generate new insights that not only shape new inquiries but also translate them into practice" (Thorne, 2016, p. 40). Thus, interpretive description allowed for further exploration of the health care professional's experience with the implementation of BSR for the purpose of generating and interpreting new knowledge. The intent was to apply these findings and ultimately improve the BSR implementation process. Thorne (2013) stated "interpretive description implies no fixed design elements" (p. 297). Therefore, this methodology allowed the research team the freedom to choose the design elements that best suited this research study.

Methods

Study Setting and Study Participants

To recruit nurses who were members of BSR implementation teams at four Canadian hospitals, I obtained supervisory committee approval and ethics approval from the UBC Behavioural Research Ethics and Providence Health Care Research Ethics Boards. I also received approval to conduct my research study from the St. Paul's Hospital critical care Patient Care Managers. The only inclusion criterion for this study was that participants had to be health care professionals who were members of a BSR implementation team.

Sampling Plan and Recruitment

Snowball sampling was used to recruit participants for this study. According to Polit and Beck (2012) snowball sampling is used with the intention of recruiting participants through association. Therefore, study participants were recruited via referral or identification from other participants. A snowball sampling technique, used with specific inclusion criteria, ensured the recruitment of health care professionals who had been members of BSR implementation teams with the purpose of collecting information from their experiences.

There were six nurses recruited from St. Paul's Hospital who were part of a BSR implementation team in different critical care areas. To ensure some variation within the sample, the participants included in this study were members of BSR implementation teams from different units in the hospital. The study participants had various professional roles and were all members of a BSR implementation team. The participant roles included professional practice consultants, clinical care leaders, clinical nurse specialists, clinical nurse educators and bedside nurses. In addition, there were three nurse consultants recruited, also using the snowball

technique, from Misericordia Hospital, Edmonton, AB; Bruyere Continuing Care, Ottawa, ON; and SickKids Hospital, Toronto, ON. I am using the term "nurse consultants" to refer to nurses who have been involved in the process of implementing BSR in other institutions across Canada. By interviewing nurse consultants, I was able to obtain a more in-depth understanding and a greater range of perspectives on the BSR implementation process.

All study participants were recruited via email invitation. The email invitation (Appendix A) was sent by a professional practice consultant at St. Paul's Hospital who was not a member of the research team. The email invitation included information about the study, members of my research team, and the anticipated time commitment. I was contacted directly via email by interested participants. Upon receiving confirmation that the potential participants met the inclusion criteria, I sent an information letter (Appendix C) with a more detailed explanation of the study and a consent form (Appendix D), and set up a time and place to meet for the interview.

Data Collection and Analysis

Data collection and analysis were guided by interpretive description. Interviewing was chosen as the primary data collection method with the intention of gathering experiential knowledge from those directly involved in the phenomenon being studied (Thorne, 2016). Nine interviews were conducted using a semi-structured interview guide to explore participants' experiences and perspectives regarding the implementation of BSR in their hospital setting. Semi-structured interview questions (Appendix B) were used to enable open discussion and "flexibility" during the interview, which allowed the interviewer the opportunity to "probe" participants for more in-depth responses (Doody & Noonan, 2013; Polit & Beck, 2012). The interview questions were pre-determined based on the findings in the literature; however, I also

allowed the questions to evolve in relation to the evolving analysis as I proceeded with the data collection. The interviews were conducted via telephone or in person in a private location within St. Paul's Hospital. The interviews were audio recorded and lasted approximately 30 to 45 minutes. On completion of the interviews, the audio recordings were transcribed by an experienced confidential transcriptionist. Prior to data analysis, the transcriptions were compared with the original audio recordings to ensure the accuracy.

In line with processes of interpretive description, data collection and analysis occurred concurrently (Thorne, 2013, 2016). Thorne (2013) described the interpretive description analytic process as moving from "the self evident to that which was not previously apparent, from variation to similarity and back again" (p.301). My analytic process included noting the apparent themes and then working toward discovering new connections, patterns and relationships while questioning why they were present. Furthermore, as Thorne (2016) suggested, while engaged in the iterative process, I documented my "analytic insights" to assist in developing further considerations (p. 170). Therefore, it was possible to become fully acquainted with the data by reading and re-reading the data to ensure I was not focusing solely on the initial themes present in the data set (Thorne, 2016). This process of data collection and analysis continued until I was able to generate meaningful themes and develop analytic conclusions from health care professionals' experiences with the BSR implementation process. Overall, by using the interpretive description methodology, I was able to generate new knowledge guided by the research question and build on what was already known about the implementation of BSR (Thorne, 2013).

Credibility and Rigour

In order to ensure the credibility of the proposed study, I followed the general principles of "evaluation criteria" for interpretive description as described by Thorne (2016, p. 233). Thorne (2016) explained that "epistemological integrity" is expected thereby "the research process must reveal a research question that is consistent with the stated epistemological standpoint and interpretation of data sources and interpretive strategies that follows logically from that question" (p. 233). Secondly, Thorne (2016) stated "qualitative studies ought to show 'representative credibility' such that the theoretical claims they purport to make are consistent with the manner in which the phenomenon under study is sampled" (p. 234). Thirdly, Thorne (2016) suggested that qualitative studies need to demonstrate an "analytic logic" which requires unequivocal reasoning throughout, and an "audit trail" and "thick description" in the analysis and study findings (p. 235). Lastly, Thorne (2016) identified the importance of "interpretive authority" to be "confident as to which claims represent individual subjective truths claims and those which might be more shared or common in nature" (p. 235). To address this, I maintained a reflective journal throughout the research process for self-reflection on my personal biases, perceptions and feelings that may have influenced my interpretation of the data (Darawsheh, 2014).

Ethical Considerations

Ethical considerations were addressed, including informed consent, confidentiality, and data storage to ensure that study participants were treated with respect and fairness. I conducted the research study according to the policies, protocols, and guidelines outlined in the Tri Council Policy Statement: Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social

Sciences and Humanities Research Council of Canada, 2014), University of British Columbia Behavioural Research Ethics Board (UBC BREB), and University of British Columbia/ Providence Health Care Research Ethics Board (UBC/PHC REB). Ethical approval was obtained from the UBC/PHC REB (#H17-00425) before commencement of my research study.

Informed Consent

All study participants were required to provide written consent. The consent form contained information describing the purpose of the study, study procedures for collecting information, a plan for reporting the study results, potential risks and benefits, the commitment to confidentiality and researcher contact information (Polit & Beck, 2012). The letter of information (Appendix C) and consent form (Appendix D) were sent via email or reviewed with participants in person. Consent was obtained before commencement of the interview.

Confidentiality and Data Storage

To maintain confidentiality, an identification number was assigned to each participant and a master list matching the identification numbers with participants' names was securely stored with controlled access (Polit & Beck, 2012). The transcripts and interview notes were securely stored separate from the master list, in accordance with the UBC BREB guidelines. Electronic research data was password-protected and only supervisory committee members had access to the data. The research data was not uploaded to shared storage drives. The research data will be destroyed after five years by permanently deleting electronic files, via an appropriate method, and shredding all paper documents.

Conclusion

The qualitative method, interpretive description was used to guide this study with the intent of generating new knowledge on the process of implementing BSR that can be applied to practice. Credibility, rigour and ethics were carefully considered throughout this study. The following chapters will present the research findings and discussion, on this research study.

CHAPTER FOUR: REASEARCH FINDINGS

In this chapter I describe the findings that arose from my research process as guided by the research question "What can be learned about optimizing the implementation of bedside shift report from the perception of nurses who have implemented it?" On the basis of interviews with nine nurses who were members of BSR implementation teams, the overarching findings of my study were the complexities of practice that made implementing a nursing practice change such as BSR challenging. Throughout the interview process, I observed that BSR was a highly sensitive topic for some participants; therefore, to maintain confidentiality for all concerned, I will minimize the participant information I provide in the presentation and discussion of my findings.

There were two main themes highlighted in the research data. The first theme was the strategies participants used for implementing BSR. Overall, the participants in this study described using similar BSR implementation strategies to those identified in the literature; however, this experience allowed me to explore the implementation planning further. Five implementation strategies were prevalent in my data analysis. These strategies included creating a BSR implementation working group, group member preparation, creating staff awareness, staff education sessions and finally, the initiation of BSR.

The second theme was the challenges participants faced during the implementation of BSR. As I predicted, many of the challenges associated with BSR that were highlighted in the literature were also identified in my study interviews, although, in this study, I had the opportunity to examine and clarify, through the interview process, what these challenges were and why they occurred. On the basis of my data analysis, I discovered four main implementation challenges that can help us to understand these experiences more fully: attitudes and beliefs

about BSR; dissemination of patient information and confidentiality concerns; the impact of changing practice to BSR; and nurses negative influence on BSR. Using these findings, illustrated with material from the interviews with nurses, I will demonstrate that these four factors further exacerbate nurses' discomfort with BSR and explain how nurses describe their resistance to this change in practice. To clearly summarize the findings, I am going to first talk about participants' reflections on the implementation strategies used, followed by a summary of participants' experiences with implementing BSR.

Implementation Strategies

Most participants reported that BSR was implemented at their institution due to the focus on patient- and family-centred care practices. Generally, participants described similar strategies for implementing BSR such as creating a BSR implementation working group, group member preparation, creating staff awareness, staff education sessions and finally, BSR implementation. However, the approach and planning within each phase of the implementation process varied among participants' institutions.

Creation of a Working Group

All participants described creating a working group to prepare for the implementation of BSR. These groups generally consisted of nurses in various roles such as professional practice consultants, clinical nurse educators, clinical nurse specialists, clinical nurse leaders, and bedside nurses. Most participants also identified including patient partners in their BSR implementation working groups. Participants shared that the members of the working groups undertook extensive preparation for this practice change.

Preparation for BSR Implementation

Participants consistently explained that as members of the working groups they prepared for the implementation by learning as much as possible about BSR. One participant reported that "consultants were hired from the USA" to assist the hospital with implementing patient- and family- centred care practices, which included BSR (P1). Other participants explained that a group of nurses on the BSR implementation teams travelled to attend an International Patient and Family Centered Care Conference to gain knowledge on BSR. One participant shared that a team of nurses from her hospital travelled to a hospital in another province where BSR was implemented. She explained that this was helpful for the team as they gained knowledge about the BSR implementation process, observed the practice being done and were ultimately able to share this knowledge with other members of the BSR implementation team.

In addition, participants also described how they reviewed the literature on BSR to prepare for the implementation process. One participant shared that her team used a tool to guide the implementation of BSR created by the *Agency for Healthcare Research and Quality*. Generally, however, participants revealed that they did not refer to any specific tools to guide the implementation of BSR. Participants commonly described that members of the working groups met regularly to develop BSR education materials for staff education on the practice and to create timelines for the implementation of BSR. Participants reported that preparation for the implementation took approximately two to four months.

A number of participants stated that guidelines for conducting BSR were created prior to the implementation process. One participant shared that the guidelines her team developed were used to implement BSR across all hospital units. She also mentioned that a hospital-wide policy on BSR was created six months after implementation of the practice. Similarly, another

participant identified that BSR was initially introduced as a hospital policy and, therefore, was simultaneously implemented in all hospital units.

Creating Staff Awareness of BSR

Participants commonly identified the importance of ensuring that staff were aware that BSR was coming. Participants discussed at length the working group members' approach to creating staff awareness concerning the implementation of BSR. A number of participants stated that posters with nurses enacting BSR were put up on units to create awareness of the imminent change in practice. Other participants mentioned that BSR was introduced at staff meetings, which allowed staff time for discussion about the practice change. In addition, participants explained that informal "staff huddles" were frequently conducted by members of the implementation teams to familiarize staff with BSR and answer questions about the practice change. One participant also mentioned that information on BSR was printed in the monthly newsletter to create staff awareness. In addition, participants reported that regular staff surveys were conducted prior to the implementation of BSR to assess staff knowledge in regard to BSR and identify learning needs. Participants reported that the information collected from the staff surveys was commonly used to develop the plan for BSR education that was provided to staff prior to the implementation.

BSR Staff Education Sessions

Participants explained that once the implementation teams created awareness about the new reporting method, nursing staff were educated on how to conduct report at the bedside. Participants described a variety of ways BSR information was disseminated. Most participants reported that nursing staff were expected to attend formal education sessions on BSR, ranging

from approximately one and a half to four hours long. A number of participants reported that nursing staff were invited to these sessions via a letter signed by their patient care manager that was attached to their pay stub. These participants also mentioned that nursing staff were paid to attend the formal BSR education sessions. Some participants identified that staff members were required to conduct online learning modules prior to the BSR education sessions. Participants commonly identified that members of the BSR implementation team used power point presentations to teach staff about BSR, followed by playing videos that demonstrated the practice. In addition, some participants reported having nursing staff conduct BSR role playing as part of their learning sessions. Some participants also mentioned developing BSR reference cards and reporting tools to assist staff with conducting the practice.

A number of participants stated that a presentation by a hospital lawyer was included in the education sessions in order to explain confidentiality principles and rules and discuss staff concerns around confidentiality. Furthermore, participants unanimously identified that patient partners were also included in the education sessions. Patient partners were there to share their hospital experiences and support for BSR with nursing staff. Participants explained that having patient partners present was meant to provide staff with patients' perspectives on the practice and to reassure staff that patients support the concept of nurses conducting report at the bedside.

Initiation of BSR

Participants described similar approaches to the initiation of the practice. Participants pointed out that timelines were created during the preparation phase and included the target date for implementation of the practice. Brochures or pamphlets were commonly created by members of the working groups for the purpose of informing patients and families about BSR. Participants explained that nursing staff were expected to ensure that patients or families were

provided with the brochure so they were informed about the BSR process and could provide consent for BSR.

Generally, participants reported that members of the implementation teams were present at the time of shift changes for the period during which BSR was being implemented. Participants commonly reported that this occurred for approximately two weeks. Participants identified that members of the implementation team were present to encourage BSR, provide feedback on the practice, and assist nursing staff members with questions or concerns. One participant explained that BSR was initiated in phases on her unit, starting with private rooms then moving to multi-bed rooms to help ease staff into the practice change. Participants consistently reported having bedside nurses who were identified as nurse "champions" or experts on BSR. The idea was that these nurses were able to provide ongoing encouragement and support to nursing staff on the unit. Participants consistently reported that, a year after the implementation of BSR, members of the implementation teams continued to monitor the success of BSR by conducting regular check-ins with staff, patients, and families.

Generally, participants described similar strategies for implementing BSR. Although some of these implementation strategies were successful, there were also common challenges associated with the implementation of BSR. These challenges seemed to be impacted by the contextual factors.

BSR Implementation Challenges

Attitudes and Beliefs about BSR

Some of the challenges participants faced with the implementation of BSR arose from the attitudes and beliefs they believed nursing staff had about BSR. Participants believed that their

colleagues perceived BSR negatively and were apprehensive about the implementation of the practice. These pre-conceived beliefs posed challenges for BSR implementation teams.

Negative views of BSR.

When asked about the challenges that occurred during the implementation of BSR, participants consistently mentioned that nursing staff expressed negative views and were apprehensive about BSR prior to being educated about the upcoming practice change. Many participants mentioned that staff surveys were conducted to prepare for the implementation of BSR. The pre-implementation surveys were described as being used to assess staff members' thoughts and knowledge on BSR, and to identify learning needs to prepare for BSR education sessions. One participant explained that a pre-implementation staff survey conducted at her hospital identified that:

> *P7: A third of nurses thought this was the dumbest idea ever, "Why would we ever do this? You're going to wreck everything we do." A third, or maybe a little bit more, said, "I get why you're trying to do this. I'm worried about certain things, but I get it." A third said, "why aren't we doing this already?"*

This participant revealed that her implementation team faced a major challenge trying to change the staff members' negative perceptions of BSR.

Another participant shared that nursing staff at her hospital were unhappy about the practice change. This participant reflected on her experiences educating nursing staff on BSR.

> *P8: They were very stressed out coming in the door, whether it was related to pre-information they had received, the pre-survey or the letter. People came in the door quite defensive.*

This participant also believed that the staff members who viewed BSR negatively posed challenges due to the influence of their negative views on other staff members. The participant stated:

> *P8: If they catch wind of it through the rumour mill, they will fill in the gaps. All their assumptions they will fill in with stuff grown out of their anxiety and fear around change, not grown out of this exciting change.*

This strong resistance to BSR seemed to be a common challenge implementation teams were faced with.

Apprehension about BSR.

It was reported that nursing staff were also apprehensive about the practice. Participants commonly mentioned that nursing staff expressed uncertainty about how BSR would benefit patients and families. One participant described her experience with reactions from nursing staff during an education session on BSR.

> *P7: What I encountered was a lot of nurses had assumptions about what benefit this may or may not have for patients and families, but we never actually verified those assumptions with patients and families.*

This participant seemed to be frustrated that nursing staff had developed assumptions about BSR prior to having all the information about the practice. One participant shared that, even though she was part of the BSR implementation team, she had a similar reaction as nursing staff when she was told the practice change would be occurring on her unit. She described that she was initially unsure about the benefits of BSR.

> *P1: I was quite skeptical about how it was going to work and how it was going to aid the patient. Was it going to be more disruptive to the patient? That's what was going through my mind.*

Another participant identified that a survey on BSR, conducted four years after implementing the practice at her hospital, indicated that some nursing staff were still unclear on the benefits of the practice.

> *P4: Despite the large scale implementation, which highlighted all the benefits, there were still some that answered, no, they did not know the benefits of bedside handover.*

Furthermore, a participant also explained that during the education sessions nurses expressed "frustration" about having to do BSR. She stated nurses approached her with comments such as:

> *P8: Why are we bearing the brunt of having to be the ones who share the information when the interdisciplinary team should be doing this? We should be doing this as a whole organization. Why is this a nursing change?*

Participants pointed out that they identified that staff had negative views and were apprehensive about BSR early on in the implementation process which allowed for time to prepare for addressing this challenge.

Many participants identified that patient partners were asked to participate on BSR implementation teams to provide their input and perspective on the practice. Including patients in the process was reported by participants as a way to address the negative views and apprehensiveness expressed by nursing staff. Participants commonly stated that patient partners presented at staff education sessions to provide their perspective on what BSR meant for them. Participants described what the patient partners shared at the education sessions.

> *P3: The patient partner spoke about their stay and how meaningful it would have been to have their family member participate in bedside shift report, which I think was helpful to some people in understanding why it's (BSR) important.*

> *P6: We had stories from patients to say how things had gone somewhat sideways and that if they had that opportunity to hear one person handing over information to the other to get an understanding of what was going on, it might have made their situation better.*

Participants seemed to believe that having patients share their stories was an effective way to relieve some of the concerns and skepticism expressed by nursing staff.

Due to these challenges faced at the beginning stages of the implementation process, participants were inclined to make recommendations during the interviews on practices they believed may have worked better. Reviewing the literature and understanding the evidence around BSR were identified as important parts of preparing for the implementation process. One

participant explained how negative views of BSR had had an impact on her response to these views.

> *P9: I had a lot of negative reactions from the bedside nurses and lots of discussions that made me realize I really wanted to have a solid foundation in the literature so I could speak freely, and that I was not just pressing how I thought it (BSR) was going to be beneficial.*

Another participant recommended introducing the idea of patient- and family-centred care early on in the process.

> *P7: Just get talking about what family- centred care means for nurses, and what that means for their practice and how they see patients, because you'll uncover a lot of "the family belongs over there" and "you sit over here".*

This participant also reported that she believed it would be beneficial to bring family presence into the hospital in other ways prior to implementing BSR. Generally, participants highlighted that having good knowledge of the literature on BSR was helpful when dealing with staff who expressed negative views and apprehensiveness around BSR, because it prepared them for the challenging questions staff posed.

Negative views and apprehensiveness were just some of challenges, identified in the data, participants faced around the attitudes and beliefs of nursing staff in regard to the implementation of BSR. The negative views of some staff members made it difficult for implementation teams because these views prevented other staff members from recognizing the benefits of BSR.

Concerns about Dissemination of Information and Breaching Patient Confidentiality

In addition to nurses' expressions of negative views and apprehensiveness, it was also identified that nursing staff were concerned about the dissemination of information and breaching patient confidentiality when reporting at the bedside. Participants explained that, as a

result of the knowledge gathered from the literature and the surveys conducted prior to implementation of BSR, concerns around breaching confidentiality were identified as significant challenges that needed to be addressed.

Sharing patient information.

Some participants mentioned that nurses expressed uneasiness with the possibility that they might share information during BSR that had not yet been shared by the physician. One participant reported nursing staff concerns,

> *P2: There were all these concerns in the beginning-what about confidentiality, what if we tell patients information they don't know?*

Another participant explained how nursing staff on her unit were specifically concerned about sharing new medical information with patients and families.

> *P3: People were concerned about sharing information if a physician hasn't communicated with the family about a test result, or maybe something that happened with the patient during the day.*

These comments seem to suggest that nursing staff were uncomfortable making decisions about what information was appropriate to share with patients if the information had not yet been shared by the physician.

Legal concerns.

Moreover, participants consistently mentioned that nurses expressed their discomfort with having to conduct report at the bedside due to concerns around privacy and confidentiality. Participants described that the concerns surrounding confidentiality varied based on the type of unit in which BSR was being implemented. A common concern described by participants centred on reporting at the bedside in a multi-bed room. Even with patients and families consenting to BSR, participants explained that nurses believed privacy and confidentiality would

not be maintained if BSR was conducted in a multi-bed room because other patients could hear the information being discussed during handover.

Additionally, participants explained that staff expressed concerns about sharing information with family members when patients were critically ill and could not speak for themselves. One participant explained:

> *P6: Nurses were very worried about temporary substitute decision makers and how to know that you had the right family member.*

Similarly, another participant stated that staff members in a critical care unit where she was involved in implementing BSR also had concerns in regard to a temporary substitute decision maker (TSDM). She explained that nurses expressed concern about how they would ensure they were reporting to the right family member when conducting BSR. This participant explained:

> *P7: Unpredictable admissions added a layer of complexity and we had to kind of figure out how bedside shift report was going to be fit into this critical care environment.*

This participant also mentioned that there was extensive discussion around this topic, which ultimately led to a practice change on the identification of a TSDM.

Participants described similar approaches to addressing these concerns, including recommending addressing these concerns during staff education sessions on BSR with the presence of a hospital lawyer and a patient partner. One participant mentioned that the BSR working group members consulted the hospital lawyer at her hospital to review the confidentiality risks associated with conducting handover at the bedside (P1). She explained that this knowledge assisted the members of the working group with addressing staff concerns. Similarly, two participants identified that the hospital lawyer was consulted in regard to

confidentiality and disclosure concerns at their hospitals and attended the staff education sessions on BSR.

> *P9: She (lawyer) went through some of the actual laws around both privacy and confidentiality and disclosure and that was really beneficial because people had tons of questions, and they loved being able to talk to somebody like this.*

> *P3: Risk management popped in during the education sessions to go over some privacy and confidentiality things. This covered a lot of concerns in great detail, which was helpful for staff.*

These participants reflected on the need for support from the hospital lawyer when it came to addressing the confidentiality concerns of staff.

In addition to having the hospital lawyer present, participants reported that patient partners presented at education sessions, to not only provide their perspective on BSR but to alleviate staff concerns about confidentiality. One participant described what a patient partner shared at the BSR education sessions.

> *P7: I know you are worried that I'm worried about privacy, but that is not my concern. I just want the information.*

Although the expectation of having patient partners involved in the education process was to alleviate staff concerns about confidentiality, it is unclear how successful this strategy was.

Nevertheless, according to one participant, it was possible to come up with constructive solutions for maintaining confidentiality and managing the dissemination of information. Two years after the implementation of BSR at her hospital, nursing staff ultimately learned to constructively manage some of their concerns around confidentiality.

> *P2: Now nurses manage [the information sharing] by asking at rounds if there is anything that shouldn't be shared with patients and then they take it outside the room.*

Although participants identified that staff had numerous concerns in regard to dissemination of information and confidentiality, this statement demonstrates the possibility and feasibility of

overcoming some of these concerns over time. Confidentiality was noted by participants to be a significant concern for nursing staff when it came to this practice change. Participants recommended the inclusion of a hospital lawyer and a patient partner when educating nursing staff on BSR; however, even with this strategy, it seems confidentiality remained a concern for some nursing staff.

The Impact of Changing Practice to BSR

In addition to the previously mentioned challenges, participants reported two other key factors that led to nurses' resistance to implementing BSR. First, the language required for BSR was not nurses' natural way of communicating. Second, participants reported that when the process of implementing BSR began, there was the realization that nursing handover had another purpose for nurses besides the exchange of patient information. Nursing handover was described by participants as being a time for nurses to debrief about their day and to connect with each other on a social level. These two factors added to the challenge of implementing this practice change.

Disruptions to Familiar Communication.

Some participants believed that disruption to nurses' natural communication style contributed to the resistance by nursing staff to conduct BSR. One participant believed this was one of the reasons that prevented some nursing staff at her hospital from conducting BSR. This participant described that staff avoided practicing BSR so they did not have to alter how they provided handover to the oncoming nurse.

> *P3: Some nurses feel very strongly about it being their report and their time, and they don't want to necessarily adjust their language or take that few extra minutes when a family is present.*

Another participant explained that she believed nurses often have difficulty communicating to patients and families who have different levels of health literacy. She described that reporting in lay terms was hard for some nurses.

> *P2: I think that health literacy is an incredibly powerful thing for nurses that we don't always understand. BSR helps nurses to acknowledge the health literacy of patients and families because we are meant to be explaining things in easy to understand terms.*

Speaking in lay terms was not consistently identified by participants as an issue for BSR implementation because in some participant hospitals nurses were not expected to alter their language to lay terms when conducting BSR.

One participant explained that effective communication is important when conducting BSR to ensure the correct information is passed on to one's colleagues.

> *P2: BSR means accountability and doing your assessments. Being able to articulate that to your colleague is very important.*

Furthermore, participants called attention to the fact that conducting BSR meant nurses were expected not only to communicate effectively, but to demonstrate professionalism and accountability to colleagues and patients and families. As one participant described:

> *P8: There is the vulnerability of having an audience while you're doing handover and that impacts nurses' jobs in a few ways. It brushes us up professionally to just speaking objectively about our patients and it removes that extra flavor we sometimes throw in there when we are doing handover.*

Although BSR was identified by many participants as interfering with nurses' natural way of communicating, one participant shared that two years after the implementation of BSR, a nurse initiated survey showed that conducting BSR had a positive impact on nurses' communication skills.

> *P2: Nurses feel that their communication has improved with patients and families, their understanding of the patient's condition has improved and their accountability has improved.*

This participant explained that nurses were able to improve their communication skills with ongoing support and coaching from members of the BSR implementation team.

Comments about communicating in unfamiliar ways highlighted apprehensions about adopting BSR. Conducting handover in front of patients and families added the expectation of being thoughtful in regard to what was being said, and demonstrating professionalism. This seemed to be viewed by nurses as an element of BSR they were not willing to accept; however, as one participant experienced, it was possible to overcome this challenge with time and experience.

Interference with debriefing and social time.

A number of participants believed that some opposition to BSR was due not only to the disruption in communication, but to the reduced time for nurses to share their shift experiences and socialize with their colleagues. One participant described why she believed nurses were averse to BSR.

> *P8: It's a tough thing for people who are used to having an opportunity to maybe vent a little bit about a bad day or share something that happened that was really hard to watch and that camaraderie element that happens in that little chat.*

This suggests that nurses believed moving report to the bedside meant they could no longer share how their shift went with their colleagues. Debriefing with colleagues at the end of shift was identified by participants as an important part of handover that nurses did not want to give up. It seemed this was an element of handover that was not identified by many participants' working groups during the implementation of BSR.

In addition, nursing handover was also identified by participants as a social time for nursing staff. Conducting report at the bedside interrupted this social aspect of nursing handover. One participant explained that there was resistance to change on her unit in the

beginning stages of BSR implementation due to report time being viewed by nurses as a time to socialize.

> *P2: They liked to get together and socialize. It wasn't patient focused at all. It was a social event. I think many of the older nurses missed that piece- the social aspect.*

Generally, through this process of implementing BSR, participants realized that nursing report meant more to nurses than just the sharing of patient information; therefore, having identified this, participants also recommended what would have worked better. One participant believed that it would be beneficial to explore the meaning of nursing report for nurses prior to implementing BSR.

> *P4: Really unpacking what report time means to them because there's a social aspect to it but also people want to get out of work on time, so they want report to be succinct.*

She pointed out that it would have been advantageous to identify the meaning of the existing handover format for nurses, because this information could have been used to ease the transition to BSR.

Generally, it seemed that BSR was viewed by nursing staff as a disruption to the long-standing practice of handover. According to participants, nursing staff seemed to be extremely resistant to changing the way they were accustomed to communicating with each other. It also seemed that nursing staff believed that adopting BSR meant they were losing aspects of handover, that they felt were important.

Nurses Negative Influence on BSR

Participants discussed at length how nursing staff influencing their colleagues impacted the various phases of the BSR implementation process. These influences were mentioned by participants throughout the interviews, notably, in regard to the negative views expressed by

nursing staff in the pre-implementation phase and the refusal by nursing staff to conduct BSR in the post-implementation phase.

Naysayers.

Most participants explained how staff nurses, identified as "naysayers," influenced colleagues in the introductory phase of BSR implementation. Naysayers were identified as staff members who were against the implementation of BSR. One participant stated:

P1: Naysayers often influenced doubt about BSR among other staff members.

A participant described how in the pre-implementation phase, a group of nurses at her hospital attempted to interfere with the implementation process.

P7: The group tried to sabotage the practice change by saying: "nobody likes this or wants to do it."

This participant reflected on how a particular group of nurses influenced other staff on the unit, leading to their refusal to conduct BSR.

Because naysayer interference was a common issue faced by participants, they were inclined to make recommendations for addressing the issue. One participant described her implementation team's approach to naysayers.

P5: There's the idea that if you encourage the newer/younger nurses to adopt the change the naysayers will be the odd ones out.

Another participant made similar recommendations for addressing this issue.

P3: Really try to get the in-betweeners onboard, and then you can get most of your staff on board and it will just become part of the culture.

Although naysayers were identified as causing added challenges to the implementation process, it seemed participants were able to identify ways for dealing with the negative influencers.

Bullies and Peer Pressure.

In addition, participants reported that the intra-professional influences nurses experienced had an impact on the implementation of BSR. Participants used words such as "bullying" and "peer pressure" to describe interactions among some nursing staff when it came to conducting BSR. Participants commonly described situations where one nurse would be prepared to conduct report at the bedside and the other nurse would be unwilling to participate. One participant explained:

> *P6: Bullying in the unit impacted relationships with colleagues. I think what was happening was they didn't really know how to handle the situation. They were just deferring to the person who didn't want to do it by not doing it. I'm not sure how that ever got explained to the patient who was waiting for BSR to happen.*

Another participant mentioned that, at her hospital, they had to develop strategies to deal with nurses' negative influence on other nursing staff.

> *P3: You have to watch out for the bullies, so that's why you do shadow shifts and feedback sessions. If they see the manager, the bullies back off.*

Resistors.

As well as bullying, participants also described that there were nursing staff who continually resisted conducting the practice. A participant pointed out that it was challenging for nurses who were willing to conduct BSR when there was resistance from there colleagues:

> *P9: It becomes hard when somebody else doesn't want to do BSR. We had some discussions about those interactions, and I tried to stress strategies on how to deal with it and how to get your colleague to do it.*

Another participant reflected on the ongoing resistance at her hospital after the implementation of BSR:

> *P2: 6 months into it, as a manager you would walk around during shift report and you would see some of the older nurses still having people come to them in the nursing station.*

Stymied Culture Change.

Moreover, some participants believed that the nurses' negative influence on each other was blocking culture change on the unit. One participant stated:

> *P8: The culture on a unit or the dynamic of the staff or the period of time may not be optimal for a major change.*

It was evident that this challenge was troubling for participants as many of them had thought it through enough to have recommendations about how to overcome this issue.

> *P3: It's really about changing the culture on the unit, which the literature will tell you. You need these champions on each unit and that's really what's going to help change the culture.*

Many participants believed it was beneficial having members of the leadership team, such as managers, present during shift change as this seemed to minimize the bullying and resistance to the practice. One participant explained her belief that leadership has the power to influence those who are resistant to change.

> *P5: It's probably old school, but sometimes I think when things aren't being adopted, there needs to be someone from above that says, "This has to be adopted. It's culture now. It's part of our strategic direction. I expect this to be happening"*

Although this issue seemed to have the biggest influence on the final implementation phase, nurses' negative influences on their peers impacted the BSR implementation process throughout. Participants frequently identified that support from leadership was one way to address this problem.

Summary

These findings provide insight into the experiences of implementing BSR. Participants' experiences highlighted the impact of attitudes and beliefs, dissemination of information and breaching confidentiality, changing practice and nurses' negative influence on BSR. Overall,

participants faced similar challenges and used similar strategies for implementing BSR. Although the challenges were similar, the degree to which these experiences influenced the implementation process differed. Participants often had recommendations for addressing the many challenges of introducing and operationalizing BSR.

CHAPTER FIVE: DISCUSSION

Bedside shift report (BSR) is a change in nursing practice commonly being implemented in health care institutions as a way of promoting patient- and family- centred care. Current literature highlights experiences with strategies used in the implementation of BSR and elaborates on the challenges that have been encountered. Examining nurses' experiences on BSR implementation teams will potentially facilitate a more effective way to implement this practice.

In this study, I interviewed nurses from four Canadian hospitals who were involved in the implementation of BSR. As expected, many of the strategies and challenges reported by the participants in this study were similar to what had been reported in the literature; however, I was able to explore these challenges in more detail and acquire a better understanding as to why the challenges occurred. Resistance to BSR was a significant challenge for participants in this study, and through my analysis of the data I found two apparent causes for the resistance.

In this chapter, I will discuss what I consider to be the two most notable findings of my study: the extent to which BSR interrupts familiar practice norms and the complications that this new approach brings to situations where there are problematic relational dynamics that affect nurses. I will proceed to discuss these findings in light of current literature. Finally, I will review the potential implications of these findings, consider recommendations for further research and practice and comment on the strengths and limitations associated with this study.

Interruptions to the Familiar Practice Norms

Although resistance to the implementation of BSR was described in the literature, none of the prior studies examined this in depth from the perspective of nurses involved directly with the practice change. In the analysis of my data, what nurses' accounts made evident was the extent

to which BSR disrupted practices that clearly had meaning and relevance for those engaged in them. Moreover, my findings demonstrated that there were multiple aspects of current handover practices that were different from BSR and required change. These expected changes seemed to exacerbate nurses' resistance to conducting BSR.

This study revealed that BSR interrupted communication style in multiple ways, and this was viewed as interfering with well-established handover routines. Nurses in this study reported that it was challenging to assess the health literacy of the patients and families to ensure they were able to participate in BSR to the extent they desired. In some institutions, nurses also found it challenging having to translate or paraphrase medical terminology into lay terms when reporting in the presence of patients and families. This challenge was previously reported, although authors described various other concerns with regard to communication during BSR that differed from the findings in this study (Anderson, Malone, Shanahan & Manning, 2014; Cairns et al., 2013; Chaboyer et al., 2009; Evans et al., 2012; Jeffs et al., 2013; Kassean et al., 2005; Thomas & Donohue-Porter, 2012;). Burke and McLaughlin (2013) explained that, in preparation for the implementation of BSR on a cardiology unit, a nurse expressed concern that she might not be able to answer questions asked by patients during BSR. In a qualitative study on nurses' perceptions of BSR, Grimshaw, Hatch, Willard and Abraham (2016) identified that nurses preferred to conduct report outside the patient's room so that they would not be constrained by what was said in front of patients. These findings suggested that communicating handover in front of patients adds a complexity to BSR that nurses believed they were unprepared for.

In contrast to findings from prior studies, participants in this study described that conducting BSR meant that nurses were expected to exhibit professional behaviour when

communicating with colleagues in front of patients and families, adding a formality to handover that was not formerly required and posed a challenge for some nurses. In a survey done by Schirm, Banz, Swartz, and Richmond (2018) on nurse perceptions of BSR, participants identified that nurses perceived that BSR brought a professionalism to handover that did not exist previously. Similarly, in a qualitative study exploring nurses' experiences and perceptions of BSR, Jeffs et al. (2013) found that nurses positively viewed the improved professionalism associated with BSR. Interestingly, the findings from my study indicated that nurses were resistant to BSR because they viewed their current informal handover practices as more desirable.

One participant in this study believed that BSR disrupted the current handover practice because it had to be more objective, whereas previously handover may also have contained some subjective elements. Before the implementation of BSR, handover often occurred outside the patient's room, which allowed nurses to make subjective comments about the patient's status. In addition, according to research on nursing handover practices, the information provided during handover varied in structure and relevance and may have lacked accuracy (David, Holroyd, Jackson & Cleary, 2017; Foster-Hunt, Parush, Ellis, Thomas & Rashotte, 2014;). My finding suggested that nurses were challenged by the fact that conducting BSR in front of patients and families required a more objective approach to handover, necessitating that report be concise and accurate.

In addition to the objectivity required with this new reporting format, the accounts of nurses in this study revealed that BSR represented a new level of accountability that was being asked of them. Participants identified that BSR added the expectation of providing an accurate systematic handover and required nurses to explain to their colleagues why expected tasks may

not have been completed during their shifts. This was perceived by participants as something that required more effort and time, a characteristic that not all nurses were willing to accept. Furthermore, BSR required nurses to be aware of confidential matters that could not be discussed in front of patients and families. Looking into the larger body of research on BSR, there was some evidence that nurses' satisfaction with BSR improved after communication training (Anderson et al., 2014; Slade, Pun, Murray, & Eggins, 2018) and when a standardized approach to conducting BSR was implemented (Groves, Manges & Scott-Cawiezell, 2016; Hada et al., 2018). Moreover, in the literature on nurses' perceptions after implementation of BSR, it was reported that nurses viewed the increase in accountability as a positive aspect of the practice (Groves et al., 2016; Jeffs et al., 2013; McMurray et al., 2010; Small & Fitzpatrick, 2017; Schirm et al., 2018). This seemed to suggest the possibility that this barrier to a new level of accountability could be overcome. The findings from my study supported the idea that BSR education should include communication training to assist nurses with developing good communication skills to support their interactions with colleagues, patients, and families.

A noteworthy finding of my study centered on the comments that nurses believed BSR took away from their time to socialize with colleagues and debrief about their day as a whole. Firstly, the participants noted that handover was a time when nurses tended to socialize with each other on a personal level. This finding was consistent with the findings of a study conducted by Wakefield et al. (2012), examining BSR before and after implementation on a medical-surgical unit; "reducing nurses' socialization time" was identified as a potential barrier to the transition of BSR (p. 249). The findings in this study indicated that nurses valued this social time, and thus interference with it might create resistance to the implementation of BSR.

Secondly, handover was also a time when nurses debriefed with colleagues about their shift in general or in its larger context. In the study reported here, BSR was viewed as interfering with this valuable time for sharing experiences. Debriefing with colleagues played a critical role in helping nurses cope with moral ambiguities; eliminating this aspect of handover was perceived by the nurses in this study as a profound loss. In the body of research on moral distress, it has been noted that nurses cope with moral distress by talking and reflecting with colleagues (de Veer, Franke, Struijs & Willems, 2013; Henrich et al., 2017; Schaefer, Zoboli & Vieira, 2018). Similarly, in an older qualitative study on the functions of handover, Kerr (2001) found that handover served the function of providing moral support. My finding emphasized an important aspect of nursing handover that may have been overlooked with the implementation of BSR. Although this was a modification to a long established routine, an important aspect to consider was that nurses viewed the implementation of BSR as a loss of a formerly meaningful practice. It was not surprising that nurses in this study considered BSR to be a significant practice change as they regarded it as remarkably different from their usual way of conducting handover.

Complications Due to Problematic Relational Dynamics in Nursing

A second major finding in this study pertained to the manner in which problematic relational dynamics in nursing influenced the implementation of BSR. While some previous studies had noted challenges with the implementation of BSR due to nurses' pre-conceived beliefs and negative views toward the practice (Anderson & Mangino, 2006; Kassean et al., 2005; McMurray et al., 2010; Radtke, 2013; Thomas & Donohue-Porter, 2012; Wakefield et al., 2012), in this study the impact of relational dynamics seemed to be a more prominent complicating factor. For example, numerous nurses attributed the resistance to BSR to the

influence of naysayers, bullying and peer pressure, as well as to the phenomenon I have termed "stymied culture". Moreover, most of the study participants addressed these aspects of resistance in their accounts of the BSR implementation process. This was an unexpected finding, given the lack of emphasis in prior literature; however, once relational dynamics became evident in early interviews, I continued to probe and focused attention on the issue in subsequent interviews. It became apparent that it was an area of concern for all study participants.

Participants in this study identified “naysayers” as influencing resistance to BSR. The naysayers are described by nurses as being unwilling to learn about BSR and as persons creating doubt among their colleagues. One participant reported that the naysayers at her hospital significantly interfered with the implementation of BSR and even refused to conduct the practice. This finding was consistent with some other study findings, where authors reported that some of their colleagues felt that BSR was a waste of time (Thomas et al., 2012) and believed that patients did not need to be involved in shift report (Schirm et al., 2018). The participants in this study commonly made recommendations during the interviews regarding how to manage naysayers, indicating that this was a major challenge encountered by BSR implementation teams.

A particularly worrisome finding in this study was the extent to which bullying and peer pressure among nurses seemed to contribute to resistance to BSR implementation. Study participants reported that the implementation phase was challenging when nurses refused to conduct BSR with colleagues who were willing to participate in the practice. Participants believed that nurses were unlikely to confront colleagues who refused to conduct BSR in order to avoid conflict. A culture of bullying has been identified in the literature as having considerable implications for nurses and creating negative work environments that can significantly impact health organizations (Canadian Nurses Association, 2014; Clearly, Hunt & Horsfall, 2010;

Johnson, 2015; Johnson & Rea, 2009; Logan & Malone, 2017). To my knowledge, no existing studies have reported specifically on bullying and peer pressure impacting the resistance to BSR. The findings from this study demonstrate how bullying can negatively impact change in the workplace. The persistent presence of bullying in nursing seemed to play a specific and counterproductive role in the implementation of a new approach such as this.

Additionally, as with other studies on the implementation of BSR, participants in this study described the challenges associated with nurses who were resistant to this practice change (Burke & McLaughlin, 2013; Cairns et al., 2013; Tobiano, Whitty, Bucknall, & Chaboyer, 2017; Wakefield et al., 2012). My participants discussed overt acts of resistance, such as nurses being completely unwilling to participate in BSR. Participants reported that resistors to the practice continued to pose challenges months after the implementation of BSR. This finding was not surprising after looking at the more recent body of research, which focuses on the re-implementation of BSR. Several authors described the reasons for the failure to sustain BSR: "lack of education" (Boshart Knowlton & Whichello, 2016, p.52; Connolly, 2017, p. 599; Scheidenhelm & Reitz, 2017, p.152) and "lack of buy-in" from nurses and leadership (Boshart et al., p.52; Scheidenhelm & Reitz, p.152). They also described the process of re-implementing and sustaining the practice (Boshart et al.; Connolly; Scheidenhelm & Reitz). This highlighted the need for implementation teams to continue to focus on sustaining BSR, even after the implementation has occurred.

Stymied culture was also identified in this study as a major barrier to the implementation and sustenance of BSR. My findings revealed that unit culture could be a determining factor in the success of implementing this practice change. This was consistent with the findings of a previous study on barriers to implementing evidence-based practice (EBP), where Williams,

Perillo and Brown (2014) conducted a review of the literature and found that workplace culture could contribute to resistance to change. The authors suggested that resistance to change could occur if the mentality of maintaining practice as it always had been existed and the nursing staff and organization did not have similar goals. Similarly, Brown, Wickline, Ecoff, and Glaser (2008) conducted a study on the perceived barriers to EBP and found that a barrier to EBP was that nursing culture's resistance to change was caused in part by interactions between nurses. A participant in my study suggested the need to identify the unit dynamic in order to determine the optimal methods for implementing change. In an ethnographic study exploring nursing faculty's perceptions of nursing culture and their role in transitioning students into this culture, Strouse and Nickerson (2016) noted that "the culture of nursing is multifaceted, multivalent and at times contradictory" and that "many factors interact and influence the culture of nursing" (p. 12-13). They further explained that, to address the issues with nursing culture, it needs to be viewed in terms of the broader contextual factors that are influential. This further demonstrated the complexity of nursing culture and may explain how the stymied culture found in this study had a negative impact on the change process.

The findings in this study indicated the possibility that disrupting familiar nursing practices and the status of nurses' relationships with their colleagues might significantly impact the success of implementing this practice change. These ideas provided some insight into the reasons for the resistance to the practice and why this turned out to be so surprisingly difficult to implement. Additionally, the findings from this study highlighted the extensive preparation and planning required for the implementation of BSR.

Implications and Recommendations for Practice

The findings from this research study give rise to several questions that would benefit from further exploration. An important initial consideration would be to identify how health care institutions view the magnitude of implementing a practice change such as BSR. Is BSR identified as a smaller change project, or one that deserves the attention and effort of a larger change project? Based on the findings in this study, I believe implementing BSR is a significant practice change that entails many more complexities than a smaller change project.

Nonetheless, the challenges associated with this practice change may not apply to the implementation of BSR but may also be relevant to changing any type of nursing practice. In a systematic review of effective strategies for implementing complex interventions in primary care, Lau et al. (2015) explained that for change to be successful, "the choice of strategies needs to be based on barriers relevant to the setting in which the implementation occurs" (p.13). The current study contributes to the literature on BSR by deepening our understanding of some of the barriers to implementing this practice.

Exploring the known barriers, such as the meaning of nurse handover and the impact of relational dynamics, prior to the implementation of BSR may provide more insight on how to effectively manage the implementation process. In order to better understand the meaning of handover practices for nurses, BSR implementation teams could conduct pre-implementation surveys to gain knowledge about handover practices and the meaning they have for nurses. This information could be used to assess how to minimize the impact of the practice change and to further assess the learning needs associated with BSR. A qualitative study exploring the meaning of handover practices for nurses may provide useful insights for changing or adapting handover practices in the future.

In addition, implementation teams should consider assessing the relational dynamics in the area in which BSR is being implemented. The findings in this study revealed the major impact that nursing culture and bullying can have on implementing BSR. Implementation teams would benefit from exploring the practice environment and considering if nurses are used to experiencing change or if the environment is static. Implementation teams should also consider the workload and the timing of the implementation to assist with determining the best methods for implementing change. Moreover, there is a need for implementation teams to consider incorporating education on bullying in BSR education, which could include providing education on communication to further assist nurses to deal with these problematic relational dynamics. I believe it will require a high level of concerted effort to think about what we can do to change relational dynamics in nursing. Further research opportunities could include conducting qualitative research to explore nursing perspectives on relational nursing dynamics and their impact on the practice environments and implementing change. Additionally, it may be useful to explore the impact bullying has on implementing change in nursing practice.

Study Strengths and Limitations

In this study, I was able to conduct in-depth interviews with nurses who were directly involved in the process of implementing BSR, resulting in some rich data focused on aspects of BSR itself and the factors impeding its implementation. The nurses in this study were from four different hospitals and experienced the implementation of BSR on various medical wards, which allowed for broad perspectives on the topic. This study adds to the literature on the implementation of BSR by providing a deeper understanding of the complicated factors that lead to nurses' resistance to this practice change.

My findings are limited to the experiences of the participants in this study. The participants in this study were part of BSR implementation teams and had various nursing roles; however, few of the participants were bedside nurses who were conducting the practice. Including bedside nurses, such a BSR "nurse champions" in this study could have further strengthened my findings by adding more insight into the factors that contribute to the resistance of BSR. In addition, participants in this study were recruited from four hospitals in Canada. It may have been beneficial to include participants from other institutions within Canada or beyond.

Conclusion

The findings from this study expand on the current literature on BSR implementation. Prior research has identified that resistance to BSR is a common challenge experienced by implementation teams. Although the findings in this study are similar to previous research, this study adds to the literature by deepening our understanding of the aspects of resistance to BSR. Furthermore, these results draw attention to the need to ensure better processes for BSR implementation and its sustainability.

Two notable findings, highlighted in this study, are associated with resistance to BSR implementation. The first finding is the interruption to familiar practice norms. BSR is thought to interfere with regular handover communication and the social aspects associated with handover as well as the valuable time to debrief with colleagues. In addition, the need to provide handover objectively, be accountable and portray professionalism are also considered reasons for resistance to BSR. The second finding is complications due to relational dynamics in nursing. The influence of naysayers, bullying and peer pressure, and the existence of stymied culture are thought to significantly impede the implementation of BSR. These findings demonstrate that the

nursing environment is a complex environment that deserves careful consideration when implementing change.

Now that some of the more in-depth reasons for resistance to BSR are identified, implementation teams could look at addressing these concerns prior to implementation of the practice. I suggest a thorough assessment of the nursing environment prior to the implementation of the practice to assist with determining the appropriate methods for successful implementation. I also recommend including education on bullying and communication in the BSR education for nursing staff. Furthermore, future qualitative research exploring the meaning of nursing handover and nursing perspectives on relational dynamics in nursing and the impact on practice environments may provide information to further assist with the implementation of BSR and other nursing practice changes.

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Appendices

Appendix A: Email Invitation

THE UNIVERSITY OF BRITISH COLUMBIA
School of Nursing
T201-2211 Westbrook Mall
Vancouver, British Columbia, Canada V6T 2B5
Phone: 604 822 7422 Fax: 604 822 7466
www.nursing.ubc.ca

Providence HEALTH CARE
How you want to be treated.

Dear Potential Participant,

A team of researchers from the University of British Columbia (Dr. Sally Thorne, Kim Brownjohn, Dr. Martha Mackay and Dr. Maura MacPhee) are conducting a study "Exploring the Process of Implementing Nursing Bedside Shift Report." The purpose of this study is to add to our understanding of the successes and challenges in the process of implementing nursing bedside shift report. Our goal is to learn about your experience with the implementation process in hope of generating new knowledge that can be used to assist nursing leaders with implementing this change in practice.
We are inviting you to consider participating in this research study that involves one interview lasting approximately 30 to 45 minutes. The interview will be conducted by Kim Brownjohn in a private location or via telephone at a mutually agreeable time. If you are interested in participating in this research study, please contact Kim Brownjohn at kbrownjohn@providencehealth.bc.ca. Furthermore, we would appreciate if you could forward this email to colleagues who may be interested in participating in this study.

Sincerely,

Sally Thorne, PhD, RN, FAAN, FCAHS

Appendix B: BSR Interview Guide

1. How did the idea to change how nurses conduct handover come about at your institution?
2. How long has your institution been practicing BSR? (question will only be asked to 1 participant at each institution)
    a. How many units in your institution are currently practicing BSR?
3. I would like to talk about the process for implementing BSR for your unit:
    a. Who was involved in the implementation process?
        i. What was your role on the team?
        ii. How did you feel taking on this role? (excited/daunting?)
        iii. Were patient/family partners included in anyway in this process?
4. How did your team prepare for the implementation of BSR?
        i. Did you use a theoretical model or any specific tools to guide the practice change? (Change theory/AI/previously developed tools)
        ii. How do you feel about the preparation that was done? (effective/extensive/lacking)
    b. How long did it take to prepare for the implementation of BSR?
5. What would you have done differently or the same if you had to prepare for such a significant practice change again?
6. How did your team "roll out" this practice change?
    a. How do you feel the "roll out" of BSR went and why?
7. Can you think about what worked well for your team with implementing BSR?
    a. Why do you believe this worked well?
8. What were some of the challenges experienced with the implementation of BSR?

a. Can you think about why these challenges might have occurred?

b. What did it feel like to experience these challenges?

c. How did your team overcome these challenges?

9. How have you managed to sustain this practice change?

10. Is there anything significant about the implementation process that stands out for you?

11. What advice do you have for others looking to adopt this practice change?

Appendix C: Letter of Information

THE UNIVERSITY
OF BRITISH COLUMBIA
School of Nursing
T201-2211 Westbrook Mall
Vancouver, British Columbia, Canada V6T 2B5
Phone: 604 822 7422 Fax: 604 822 7466
www.nursing.ubc.ca

Providence HEALTH CARE
How you want to be treated.

Email Letter of Information

Dear Participant,

Thank you for your interest in participating in our study: "Exploring the Process of Implementing Nursing Bedside Shift Report." Our goal is to learn about your experience with the implementation of nursing bedside shift report.

I will contact you in the near future to set up an interview time at your convenience. The interview can be done in person if located in Vancouver, BC or over the phone. The interview will last approximately 30 to 45 minutes. The interview questions will focus on your role in the implementation process, how your team prepared for the implementation, as well as the challenges and successes of the implementation of bedside shift report at your institution.

Please refer to the attached Information and Consent Form for further information. If you have any questions prior to the interview, please do not hesitate to contact me.

Sincerely,

Kim Brownjohn RN, BScN
(604) 682-2344 x62809
kbrownjohn@providencehealth.bc.ca

Appendix D: Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA
School of Nursing
T201-2211 Westbrook Mall
Vancouver, British Columbia, Canada V6T 2B5
Phone: 604 822 7422 Fax: 604 822 7466
www.nursing.ubc.ca

Providence HEALTH CARE
How you want to be treated.

Information and Consent Form

Exploring the Implementation of Nursing Bedside Shift Report

I. STUDY TEAM - *Who is conducting the study?*

Principal Investigator:

Dr. Sally Thorne, University of British Columbia, School of Nursing, Ph: 604-822-7482, email: sally.thorne@nursing.ubc.ca

Co-Investigators:

Kim Brownjohn, University of British Columbia, School of Nursing, Ph: 604-682-2344 x62809, email: kbrownjohn@providencehealth.bc.ca
Dr. Martha Mackay, University of British Columbia, School of Nursing, Ph: 604-682-2344 x 63127, email: mmackay@providencehealth.bc.ca
Dr. Maura MacPhee, University of British Columbia, School of Nursing, Ph: 604-822-2891, email: maura.macphee@nursing.ubc.ca

II. SPONSOR- *Who is funding this study?*

None

III. INVITATION AND STUDY PURPOSE- *Why are we doing this study?*

Kim Brownjohn is conducting this study with Dr. Sally Thorne, Dr. Martha Mackay and Dr. Maura MacPhee for the required completion of her degree in a Master of Science in Nursing. The purpose of this study is to add to our understanding of the successes and challenges in the process of implementing bedside shift report. Our goal is to learn about your experience with the implementation process and potentially use this information to assist nurse leaders with implementing this change in practice.
You are being invited to take part in this research study because of your involvement and experience with the implementation of bedside shift report at your institution.

IV. STUDY PROCEDURE- ***How is the study done?***

If you agree to take part in this research study, you will be involved in one interview lasting approximately 30 to 45 minutes. You will be asked questions by Kim Brownjohn in regard to your experience with the implementation of nursing bedside shift report. During the interview you will be asked about your role in the implementation process, how the team prepared for the implementation, what challenges the team faced and what worked well for the implementation of bedside shift report. The interview will be conducted in a private location at St. Paul's Hospital or via telephone at a convenient time for you. The interview will be audio recorded, transcribed and interpreted by the interviewer (Kim Brownjohn) at a later date. Responses to the interview questions are confidential. Your interview responses will not be shared outside of the research team and will not impact your employment.

V. STUDY RESULTS

The results of this study will be reported in a graduate thesis completed by Kim Brownjohn. The study findings may be published in an academic journal and presented at conferences. No individual comments will be shared with management or supervisors, and all findings will be grouped and synthesized for reporting purposes. There will be no unit or personal identifiers on reported material. General terms (eg critical care vs general ward) will be used to signify specific clinical units rather than language that would directly identify specific units (eg CICU, ICU etc). No personal identifiers will be present in the study findings, written reports or academic presentations of this research.
Please let us know if you would like to receive a copy of the final report by leaving your email address at the end of this form.

VI. POTENTIAL RISKS OF THE STUDY- Is there any way being in this study could be bad for you?

There are no identified risks associated with being involved in this research study. You can withdraw from participating in this research study at any time.

VII. POTENTIAL BENEFITS OF THE STUDY- What are the benefits of participating?

There are no benefits to your participation in this research study. However, sharing your experience with the implementation of bedside shift report may contribute to the knowledge of this practice change.

VIII. CONFIDENTIALITY- How will your privacy be maintained?

To maintain confidentiality, any information that may identify you will be removed from all documents and an identification number will be assigned. A master list matching the identification numbers will be securely stored. All electronic documents will be kept on a local hard drive, password protected and only accessible by members of the research team (Dr. Sally

Thorne, Kim Brownjohn, Dr. Martha Mackay and Dr. Maura MacPhee).
The interview recordings will only be heard by the interviewer (Kim Brownjohn) and potentially by other members of the research team. For the duration of the project, the digital audio recording device containing the interviews will be stored in a locked filing cabinet that will only be accessible to the interviewer (Kim Brownjohn). The audio recordings will be destroyed after a period of 5 years by permanently deleting the recordings. There are no plans for secondary analysis. All documents will be destroyed after 5 years by permanently deleting electronic files and shredding all paper documents.

IX. CONTACT FOR INFORMATION ABOUT THE STUDY- Who can you contact if you have questions about the study?

If you have any questions about the study, please contact Kim Brownjohn at 604-682-2344 x62809 or kbrownjohn@providencehealthcare.bc.ca

X. CONTACT FOR COMPLAINTS- Who do I contact if I have any questions or concerns about my rights as a participant?

If you have any concerns or complaints about your rights as a research participant and/or your experience while participating in this study, contact the Research Participant Complaint Line in the University of British Columbia Office of Research Ethics by email at RSIL@ors.ubc.ca or by phone at 604-822-8598 (toll free: 1-877-822-859). Please reference the study number H17-00425 when calling so the Complaint Line staff can better assist you.

XI. PARTICIPANT CONSENT AND SIGNATURE

Taking part in this study is entirely up to you. You have the right to refuse to participate in this research study. If you decide to take part, you may choose to pull out of the study at any time without giving reason and without any negative impact on your employment.

- Your signature below indicates your consent to participate in this research study
- Your signature below also indicates that you have received a signed and dated copy of this consent form for your record

Participant Signature Date

Printed Name of Participant

Email Address if you would like to receive a copy of the final report