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Embracing Change Management Strategies in Bedside Shift Report (BSR): A Review

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Abstract

The intention of this paper is to address the existent problem of patient safety in the healthcare sector by using Lewin's model to suggest ways to spearhead organisational change in this area due to its worldwide importance. Lewin's force field analysis was used to identify driving and retraining forces to move the practice of bed shift report (BSR) from its equilibrium state to the desired goals. Three-stage model was employed to initiate change efforts directed towards attaining improved clinical outcomes for patients and providing them with optimal safety and care both during and after treatment. Effective BSR interventions and strategies were recommended to provide sufficient scope for the management to modify their work policies and practices in accordance with any latest developments taking place in the field of healthcare in general, and nursing practices in particular.

Keywords: Change Management, Patient Safety, Three-Step Change Model, Force-Field Analysis.

Introduction

"Change", is a necessary evil, which has its own share of pros and cons. On the upside, it is an important and universally acceptable benchmark of progress attained by a society. Hence, the metamorphosis which the world has and continues witnessing in the form of advent of new technologies and "boundary-challenging inventions in scientific fields" (Cameron & Green, 2015) coupled with the changing political and economic systems of different countries, including a transformation in organisations and their systems, structures, boundaries, and expectations defining the crucial employer-employee relationships. However, on the downside, 'change' as a magic potion is not easy to come by. Its successful adoption and implementation largely depends on human behaviour. Even at the organisational level, the intrinsic motivation of the people working together as part of the corporate ecosystem, to do something different and push for incremental changes at individual level to bring about a larger change at the corporate level is the main catalyst. This is easier said than done, given the amount of uncertainty engulfed around taking a new initiative or treading unknown territories, in the name of changing the existing organisational setup even for a larger

positive cause. To complicate things further, organisational members themselves are bound by organisational rules, policies and procedures. Add to it their own leanings and patronage toward other like-minded individuals and/ or groups of people within the organisation (Cameron & Green, 2015), who oppose any transformation in the existing establishment and the rules dictating it. This further convolutes the scenario, making change management a formidable task. It is not surprising then, that “60 per cent for all change management programmes hit a road block and fail to achieve their targeted outcomes” (Haynes, 2014, as cited in Beer et al., 1990; Jorgensen et al., 2008). Besides, the onus for non-performance of these initiatives lies on the change management task force entrusted with the job. They are ineffective due to obliviousness of sophisticated dynamics of change management that ultimately influence the planned outcomes. This prevents them from controlling the results of these programmes. Fortunately, a couple of change management models devised by behavioural scientists and researchers exist to serve as guideposts for those contemplating implementing change management practices in the companies. On a brighter note, the benefit is that most of these models ensure a less turbulent transition by revolving around the already complex and unpredictable human behaviour. They do so by teaching the players in the change process, including both the enablers and the recipients, the difference between the external metamorphoses taking place and the psychological transitions being experienced inside the organisation. The outcome is that the organisation responds to the new development in a planned fashion, instead of eliciting a knee-jerk reaction toward it. One such highly acclaimed models is the “unfreeze-move-refreeze model” (Bartunek & Woodman, 2015). It was propounded by Kurt Lewin in 1947 and further expanded by Schein in 1996. The model, which deploys force field analysis, which Lewin proposed in 1958, focuses on attaining improvement in group performance and sustaining it over time to achieve organisational change (Bartunek & Woodman, 2015). For this, it relies on two sets of forces; internal forces driven by a person’s or organisation’s own intrinsic needs, and external forces that are imposed by the extrinsic environment. Hence, the name force field analysis (Boohene & Williams, 2012). The outcome is an organisation-wide change process that occurs by following a three-step or three-stage model and force field analysis briefly discussed below:

- Unfreezing – Unfreezing is the first step, which, according to Boohene & Williams (2012) involves persuading people and mentally preparing them to accept change.
- Moving – Moving is the second step, and it means getting the people to accept the new state or experience felt after being exposed to the novel and desired change (Boohene & Williams, 2012).
- Refreezing – Finally, after the change has been implemented, the third or last stage of refreezing comes. It means to ensure that the new policies and behaviour incorporated by the change process are permanently imbibed or internalised in employees across the company as an inseparable part of their work operations and roles (Boohene & Williams, 2012).

Lewin suggested that the above mentioned three steps or stages of organisational change cannot be implemented without encountering two different kinds of forces. First, the driving forces which seek to promote change, and second, the restraining forces which serve to resist change and maintain the status quo. Further, for any change to take place, the aggregate of driving forces should at any time outnumber the restraining forces, since, no change can take place either when the former is less in

number than the latter or when both the forces are equal in number, a situation, which Lewin labelled as a “state of equilibrium or inertia” (Boohene & Williams, 2012). Thus, the change managers or change consultants in an organisation, who are assigned this crucial should always try to decrease resistance to change and increasing support for the forces driving change. When both the forces of resistance and support for change are equally strong, then an organisation may see itself in a stable position of performance. However, when the same organisation decides to embark upon a major change journey and ends up strategizing certain policies and processes that weaken dissent and decrease the forces of resistance to change, then its performance might elevate to a new level (Boohene & Williams, 2012). The current paper tries addressing the existent problem of patient safety in the healthcare sector by using Lewin’s model to suggest ways to spearhead organisational change in this area due to its worldwide importance.

Patient Safety: A Burning Issue in the Healthcare Sector

The demand for medical services continues to grow across the globe and even surpassing the rising costs associated with them. According to a report by Deloitte Global (2015), at present, 10.6 percent of the total global gross domestic product (GDP), which is \$7.2 trillion, is spent on healthcare. This share is expected to increase by 3.6 percent and reach a figure of \$9.3 trillion by 2018. However, despite this huge investment in this wellness industry, a wide variety of academic literature suggests that the problem of patient safety has not been adequately addressed and is a burning topic in the healthcare sector. The Institute for Safe Medication Practices Canada (ISMPC) clearly advises all long-term medical facilities to accord highest priority to patient safety as any negligence in providing it can erode consumer trust in healthcare, escalate medical costs and also exponentially raise the incidents of patient deaths and/or injuries (Sutherland, 2013). Still, the current scenario pertaining to sufficient medical procedures in place for ensuring proper patient safety and care looks grim. Existing studies indicate that medication errors, on an average claim more than 7,000 lives annually in the US alone, and usually affect 3-5 percent of in-hospital patients. However, 95 percent cases of such clinical misconduct fail to get formally documented in nursing and medical correspondence prepared by the hospitals (Carroll, 2003; Dennison, 2007; Wilkinson and Shields, 2008; DeYoung, Vanderkooi and Barletta, 2009, as cited in Sutherland, 2013). These statistics definitely establish a sense of urgency regarding the gravity of the problem, and demand the formulation and implementation of concrete actions for eradicating it. In doing so, the change effort needs to be directed toward attaining a unified goal or vision, which comprises of ensuring the achievement of improved clinical outcomes for patients

and providing them with optimal safety and care both during and after treatment. The “deontological principle of medicine” (Dekker, 2016), labels the safety and protection of a patient admitted in a medical facility as the top-most priority of every employee irrespective of his/her hierarchical position and designation in the organisation. This automatically implies that the immediate caregivers under whom the patient is undergoing treatment, mostly including the doctors, nurses, nursing managers and to some extent even the lab technicians (Dekker, 2016), are not the only members of the core team shortlisted for bearing the responsibility for achieving the goal of patient safety and security and improved medical outcomes. In fact, taking a more humanitarian approach toward the entire mission suggests that crafting a comprehensively fool-proof strategy for patient safety requires

the equal involvement of both the medical and non-medical staff. This includes being watchful of risks and means of protection everywhere in the system, be it the physical designs of medical devices and equipment used, the technology deployed, the interpersonal, intra-departmental and inter-departmental communication, coordination, and teamwork between every employee whether or not he/she is directly involved in patient care, as well as the corporate culture of the medical establishment itself, including both written and unwritten rules clearly demarcating acceptable from nonacceptable behaviours (Dekker, 2016).

Unfreezing

Lewin (1999, as cited in Boohene & Williams, 2012) clearly and deeply correlates both organisational change implementation and timely communication about it to the employees to avoid any painful situations arising out of uncertainty and ambiguity to make the adoption process a lot more smooth and seamless exercise. This suggests that proper 'communication' about the move should transcend all the three stages of 'unfreezing', 'moving', and 'refreezing', with slight tweaks in each phase depending on the objectives it seeks to achieve. Hence, communication in unfreezing stage is expected to focus more on the motivational aspects of change by urging the people to not only embrace it warmly by leaving their comfort zones but also convincingly answering their questions regarding the need for it so as to achieve the original purpose of this phase, which is to mentally prepare the organisation for change (Boohene & Williams, 2012; Connelly, 2016). This is applicable to every organisation, as evident from a number of studies. All of them suggest that communication and its various facets like exchanging information and knowledge, and outcomes, like building motivation and mutual trust through increased participation of the organisational members in decision-making (Boohene & Williams, 2012), can effectively counter any resistance to change. The importance of information communication cannot be overemphasised in a healthcare setup where the twin goals of providing both quality medical facilities without compromising on patient safety need to be achieved simultaneously. Studies by both Lang (2012) and the American Nurses Association (2012) actively recognise this and suggest that miscommunication among caregivers is responsible for rendering clinical harm to the patients in more than 80 percent of the cases of medical errors as revealed by an equal number of lawsuits filed for medical malpractices. According to Stange & Glasgow (2013), most clinical settings usually supplement basic ailment-related treatment with a host of other evidence-based healthcare (EBP) practices to enhance patient safety and recovery. Common sense suggests that these EBPs inevitably have to interact with the prevalent hospital or organisational systems and processes, which influence their (EBPs) sustenance and adoption rate in the wellness ecosystem. In other words, by choosing to be in the system, these EBP practices are already fighting a survival battle by combatting the resistant forces and in the process are also helped by the supportive forces mentioned earlier by Lewin in his force-field analysis model. Since any changes in the "organisational patterns of the hospital or clinical setting such as workflow policies" (Manchester, et al., 2014), will undoubtedly impact their (EBPs) existence and proliferation. One such EBP is the bedside shift report or BSR (Trepanier, 2016). According to Ofori-Atta (2015), it involves handing over the shift report by the off going nurse to the oncoming nurse at the patient's bedside in his/her presence to make him/her feel more participative or involved in the entire process of delivering overall treatment or medical care. This is opposed to a traditional shift handover or

reporting in which both the nurses do the needful in the absence of the patient. Ofori-Atta (2015) suggests that a normal BSR procedure broadly consists of a) introducing the patient and his family to the medical/nursing staff; b) seeking the patient's permission to involve his family members in the BSR exercise after inviting him for the same; c) opening the patient's electronic health record at his/her bedside and verbally reading it out using a lucid language devoid of any technical jargon so that both the patient and his family members can understand; d) carrying out an in-depth evaluation of both the patient and his room from a safety standpoint; and e) reviewing the tasks to be done including identifying any needs and concerns which either the patient or his family might have about the entire practice, and placating them. Here, it is important to mention that since BSR practice targets alleviation of nursing or clinical errors owing to miscommunication, the entire procedure is conducted using the "Situation Background Assessment Recommendation Thank (SBART) communication tool" (Ofori-Atta, 2015). Situation introduces the patient and his family to the oncoming nurse by the off going one, including conveying the patient's diagnoses to him (patient) and his family and updating the in-room patient information board, all of which is done by the oncoming nurse. Background sets the stage for patient participation in the BSR process, with him first being requested to attentively listen to his health history and the reasons behind his admission coupled with the estimated duration of stay, shared by the off going nurse, and then ask questions, if any. Assessment component evaluates both the patient's physical condition including complaints of any pain or uneasiness and that of the systems, by inspecting the working condition of medical equipment attached to the patient's body, such as chest and surgical drainage tubes, invasive lines, urinary drainage catheters, medication pumps, venous access devices etc. Recommendation means conveying the health goals and care plan to the patient. The off going nurse thanks the patient before leaving for the day (Ofori-Atta, 2015). Bedside shift report is gaining wide popularity for filling up the communication lacuna which is the root cause for a majority clinical errors responsible for jeopardizing patient safety as it deals with sharing "vital and focused patient information between the nurses in his/her (patient) presence" (Trepanier, 2016). Besides, it has also found favour in academic and industry literature as a proven strategy for positive outcomes at the communication level to ultimately help attain enhanced patient satisfaction and care. For instance, Bradley & Moth (2013) in a study involving three rural hospitals of South Australia demonstrated its efficacy over the conventional closed-door office handover approach in taking into account the social aspects of patients' health that are often ignored in a traditional treatment environment. The patients who participated in the research inquiry, which deployed a combination of "mixed-methods, pre-test post-test evaluation using quasi-experimental and ethnographic interviewing" (Bradley & Moth, 2013) voted for BSR due to its participative nature that allowed to break the unseen wall of superiority between the care provider and patients by keeping the latter informed first-hand about the nature of their treatment and overall progress along with the care provider responsible for monitoring it. This left them feeling valued and respected. Likewise, Wakefield, Ragan, Brand, & Tregnago (2012) reported the results of a study which they conducted in a Midwestern academic health centre having a 20-bed inpatient nursing unit. The research inquiry was designed to assess the healthcare situation post-BSR transition formally commenced in February 2009. Prior homework was done for the same in the form of examining the nurse-patient satisfaction scores with the previously existing nursing reports by reviewing them and also highlighting both the potential facilitators and

constraints of the proposed transition. However, the new BSR roll-out to the entire nursing unit began in June 2009. According to Wakefield, Ragan, Brand, & Tregnago (2012), the results obtained six months post-BSR implementation saw a marked increase of 8.7 points in six nurse-patient satisfaction scores recorded in February, alongside an increase from 20th percentile to > the 90th percentile in comparison to peer nursing units in other medical facilities lacking such bedside shift report practices. Moreover, the results of 43 client/patient interviews conducted almost 23 months after the implementation between February and March 2011 to gauge the overall perception levels toward the bedside shift report transition revealed that 72 percent of the patients appeared very satisfied with the new practice. Despite such overwhelming industry response to the BSR exercise, introducing this communication-based nursing practice in a new healthcare setup, or even in an established clinical facility is no easy task. Since, BSR like any other evidence-based healthcare solution, will be a part of the hospital it would be introduced in, and therefore, would definitely find itself at odds with certain organisational characteristics or elements that do not have the same thought process or like-minded agenda. Even though, there would be others welcoming this move warmly. Thus, going by Lewin's force-field model, BSR would have to continuously fight a series of restraining forces hell-bent on preventing change, by joining hands with the supportive driving forces adamant on change and development. Both these forces are active in the unfreezing phase of Lewin's 3-step model and will be explained next.

Restraining and Driving Forces in Implementing Bedside Shift Report (BSR)

In accordance with Lewin's belief, disrupting the state of equilibrium or inertia, where the restraining forces and the forces driving change (see figure 2 earlier) are in balance, creates conflict between both the forces and sets off the "unfreeze" stage of change. The scenario is not much different when resorting to a transition from traditional shift handover reporting to doing so at the patient's bedside in his/her presence. Since it makes both the restraining and driving forces at work, to engage in a tussle with each other. Wakefield, Ragan, Brand, & Tregnago (2012), based on the results obtained in their own research inquiry and an extensive review of existing literature on nursing practices have identified and created a list of common restraint forces and driving forces normally encountered when moving to bedside shift reporting from traditional form of shift handover among nurses. Any hospital or healthcare setup wanting to replace the practice of traditional shift handover with bedside shift reporting (BSR) practice can be expected to experience more of less the same forces.

Retraining Forces

Nurses would be deprived of their comfort zone present in the traditional process, as the new bedside shift report was engulfed with uncertainty regarding what needs to be said to the patient, and how. Apart from that, what needs to be done during bedside shift reporting would also be a cause of concern. The new process would significantly reduce the time which the nurses used to get earlier to interact and socialize privately, in the patient's absence with one another while changing shifts and exchanging reports. Nurses were also apprehensive about handling potentially difficult situations. Especially those involving holding discussion about certain sensitive issues with the patients themselves, their family members and even visitors. Finally, off going nurses were also worried about

the time taken by the oncoming nurse to reach the hospital and take charge as they might get late owing to the patients' requests to answer their queries.

Driving Forces

The existing shift reporting took place in segregation only between the nurses, with no patient involvement. Thus, the patient was deprived of knowing the true picture about his health condition and treatment progress. Bedside shift reporting would change all this by bringing the patient in the communication loop and make him feel more satisfied from the exercise. Since the communication in existing shift handover took place only between the nurses, hence, a lot of inconsistencies were found in the information communicated in shift reports. Inclusion of a third party in the form of the patient in the BSR exercise would considerably help in reducing these information anomalies. Information shared by the off going nurse with the oncoming nurse can present the latter with a quick synopsis of the patient's overall condition, thereby, enabling her to prioritize her work accordingly. This can save a lot of time that could be devoted toward taking care of the patient and interacting with him and his family members. Results of the existing studies show support for BSR practice by a majority of nurses, who themselves believe that bedside shift reporting can improve the efficiency and effectiveness of the shift report process.

Combatting Restraining Forces and Strengthening Driving Forces

Vines, Dupler, Son, & Guido (2014) have suggested the following strategies that could prove useful in overcoming resistance and strengthening support to implementation of bedside shift reporting (BSR) practice in a healthcare setup. Most of the resistance being faced by the nurses toward BSR is attitudinal in nature. It stems from their own apprehensions about the likely encroachment by the new practice on their socializing time with each other or the time spent with the patient and his family. This calls for a behaviour modification training to be imparted to the nursing staff by a team of expert trainers capable of making a strong and favourable psychological impact, and circumventing their fears and negative attitudes surrounding BSR. For this, a committee comprising of both medical and non-medical staff, including "doctors, nurses, unit managers and clinical educators" (Vines, Dupler, Son, & Guido, 2014), should be assembled in compliance with the recommendations of The Joint Commission (TJC). This team of experts should lead change and provide necessary training and guidance to nurses on the need for BSR implementation, including its benefits to the hospital in general, and to them in particular. Needless to mention, they (experts) themselves should be sufficiently knowledgeable about

BSR, and hence, should review existing literature on it, in order to both convince the nursing staff to lend support to it, while appeasing or addressing their concerns on the way. The driving forces mentioned above could also be a good starting point for propelling change. As could be seen, most of them provide a comparative assessment of traditional shift reporting and the proposed BSR practice. They focus on highlighting the nurses' experience (based on their surveyed responses) with the former practice, pinpointing its lacunas or deficiencies and then offering support for BSR as solution to these issues being faced by the staff. A healthcare facility planning a transition to BSR can adopt a similar approach.

Moving

After mentally preparing the organisational members for the upcoming change by unfreezing them from the existing status quo and convincing them to accept and start thinking about change and be receptive to it with an unbiased mind, the next phase is moving them into that promised change by introducing it. Here, it is important to note that the people have only been made to agree to embrace change in the previous unfreeze phase. It does not mean that their behaviour to accept change has become fixed or crystallized and cannot take a back-footing. It is very much fragile and susceptible to their “internal conflicts and feelings of fearfulness and uncertainty, making this phase the hardest of all, as people are still learning about the new changes and want their own time to get accustomed to it” (Connelly, 2016). Thus, the kind of communication which the change agents indulge in with the organisational members in this phase gains much more relevance than any other stage. According to Connelly (2016) a most desirable form of communication should be supportive in nature and it should focus on sustaining the trust garnered in the previous phase. For this, the organisation needs to immediately communicate a clear picture of the desired change and the benefits it would reap in the short and long-term so that people are able to hold on to their self-confidence and don't lose sight of the direction in which they are progressing. The best way to do this is through designing and repeatedly delivering training and coaching sessions for the employees and allowing them enough room to make mistakes and learn from them without imposing any penalties or punitive measures for the same. However, an important pointer here would be to continuously assess the efficacy of these training interventions, both from a cost-benefit angle as well the impact it leaves on the employees in terms of swaying them toward adopting bedside shift reporting practice. From this standpoint the evaluation of the training impact should be time bound and consider “time unit validity and time boundaries validity” (Street & Ward, 2012). Time unit validity divides the timeline for delivering training into weeks, months or years. While time boundaries validity decides the duration of the timeline, such as 6 months training, divided into two phases of 3 months each separated by one month gap in which the performance assessment takes place.

Designing and Implementing Interventions

As already mentioned earlier, the “moving” phase marks the first actual rollout of the change that was promised in the “unfreezing” phase and for which the group consensus was also obtained. Adhering to this process, BSR would be actually introduced in the “moving” phase and its implementation would also commence. For this, the change agents need to develop and implement the most effective BSR interventions and strategies. The starting point could be the committee formed in the “unfreezing” phase. These committee members can be a valuable source for leading the transition to BSR, by convincingly educating the rest of the hospital staff about the need to move to BSR, and also alleviating their concerns and successfully addressing their queries, if any (Vines, Dupler, Son, & Guido, 2014). The committee members can do this in a variety of effective ways. First, they should gain as much knowledge as possible about bedside report by studying a plethora of existing literature (Vines, Dupler, Son, & Guido, 2014) on the subject. This will prepare them to educate the staff and explain the benefits and rationale behind this step, and answer their questions. Friesen, Herbst, Turner, Speroni, & Robinson (2013) suggest going through scripts about popular communication tools for nursing handover such as SBART (discussed earlier), “Acknowledge,

Introduce, Duration, Explanation, Thank you (AIDET), and Introduction, Story, History, Assessment, Plan, Error prevention, Dialogue (ISHAPED)". The benefit would be that the trust of the staff won in the unfreeze phase would become stronger and get prevented from fading away. Second, since it is the nursing staff who will actually perform the bedside shift report exercise, it is imperative to get them involved in the process and the decisions pertaining to it from the first day (Vines, Dupler, Son, & Guido, 2014). This means every one impacted by the new change initiative should actually get involved in determining the processes and components of the actual BSR practice and the manner in which it needs to be conducted. Here, though the doctors and other clinical educators can also be involved and can offer their inputs. However, they senior medical practitioners should refrain from imposing any suggestions, since the nursing staff is usually more in touch with the patients and well aware of ground realities. This is important for making the nurses feel empowered and develop a sense of ownership toward the BSR practice and shed their hesitation or resistance to embrace it open-mindedly. Third, after devising the methodology and components of the entire bedside shift report exercise, the team should openly present and discuss clear-cut expectations or goals the new initiative purports to achieve by "organising an educational in-service" (Vines, Dupler, Son, & Guido, 2014). Further, the previously existent fears and apprehensions in the unfreezing stage also need to be addressed, substantiating the arguments with benefits produced by the new BSR healthcare practice in other medical setups that have adopted it. In addition, Burke & McLaughlin (2013) and (Cairns, Dudjak, Hoffman, & Lorenz, 2013), have suggested that the in-service can also be used for improving communication skills of the nursing staff. Role-playing exercises can be deployed for the same. These exercises, apart from attaining the outlined communication skills goal can also prove instrumental in mitigating any anxiety or nervousness of inexperienced nurses surrounding the BSR exercise and enhance their self-confidence. Finally, despite all training and coaching interventions designed to make the organisational members embrace BSR whole-heartedly, the senior change management staff should always be available when needed to address the "employees' problems and concerns, and remove mental blocks or barriers" (Vines, Dupler, Son, & Guido, 2014). Since, the practice is still new for the staff and it would require time to get used to it and incorporate it as part of the routine day-to-day work operations.

Refreezing

Refreezing is the last stage of Lewin's change model and marks a feeling of stability in the organisation once the people have mentally accepted change as the 'new normal' (Connelly, 2016), through constant training and coaching interventions doled out in the previous "moving" stage. It is at this point that the organisational members finally start forming new relationships and enter a new comfort zone consisting of their new work routine by virtue of becoming acclimatised to it. However, this stage also does not come overnight and has its own gestation period. Critics of this stage often slam it for being away from reality. They opine that imagining the systems and processes to be permanently internalised and crystallised in peoples' minds and behaviour indicates rigidity, which, if true, would make it difficult for the organisation to embark upon the next change journey, which, in the real world is unending. This is something which, in the real world happens to be true and appears to make sense. Since, fact is that in today's times the next wave of a path-breaking change could be "weeks or even days away" (Connelly, 2016), especially, if we talk about the excessively

short shelf lives of technological advancements, which emerge and die down at breakneck speeds. Thus, labelling this phase not as the ultimate and permanent destination, but rather, a temporary stopover. It implies that an organisation reaching this stage, should start functioning with a new behaviour which is flexible enough to mould itself in accordance with the dynamic environment, thereby, again opening itself for another round of unfreezing-moving-refreezing as the need arises (Connelly, 2016). In line with the preceding discussion, the “refreezing” phase for bedside shift report (BSR) commences from the time it becomes a daily work practice as part of the hospital operations. This means it has totally replaced the traditional nurse report as the primary method of shift change (Vines, Dupler, Son, & Guido, 2014). However, the manner in which a newly purchased piece of machinery needs constant care and maintenance in the form of regular oiling and lubrication to keep it functioning smoothly, the approach toward a novel organisational process or practice that has been recently embraced as part of the work culture is no different. Several methods exist and have been recommended for ensuring this. First, the senior management can make practicing the new BSR procedure in shift handover as a mandatory exercise, issuing “frequent reminders to duly comply with it, and also monitoring the same” (Salani, 2015). To popularise the practice and make it sustainable, all the medical and non-medical units can nominate a senior person through a consensus or voting. Those nominated can be entrusted with the task of acting as chief custodians for implementing the BSR methodology in their respective units or departments (Salani, 2015). In addition, to keep both the chief custodians and the other hospital staff sufficiently motivated to perform the new BSR practice as part of regular patient treatment and handling, the hospital management can also design and develop reasonable and suitable mechanisms that are aimed at rewarding both monetarily (pay raises, bonuses etc.) and non-monetarily (promotions, recognition in staff meetings etc.), those who adhere to the protocols, while at the same time reprimanding those who don’t (Malekzadeh, Mazluom, Etezadi, & Tasserri, 2013). Second, constant communication should take place in the form of debriefing sessions with performance evaluations and monitoring of the new bedside shift reporting practice also carried out by using key performance indicators (Wojciechowski, Pearsall, Murphy, & French, 2016). Further, addressing unresolved concerns also needs to be at the heart of the entire implementation exercise and the refreezing stage encompassing it. This is critical for fully embracing the new practice and also ensuring that its influence is for longer duration and does not get eroded. Else, it might make the medical staff return back to the earlier traditional shift handover practice. Moreover, seeking honest verbal feedback from the nurses regarding all the aspects of actually performing BSR should be an integral part of the communication loop to facilitate on-going improvement in it. Finally, even while “refreezing”, the management should ensure that implementation is flexible and should not leave the employees permanently immune to any new further changes, which may be dictated by the rapidly changing business environment in which the hospital operates. Thus, the new embraced BSR-based work behaviour should provide sufficient scope for the management to modify their work policies and practices in accordance with any latest developments taking place in the field of healthcare in general, and nursing practices in particular.

Conclusion

In conclusion, this paper has successfully embraced change management in bed shift report (BSR) to offer solution to the issues faced during day to day work operations. New mechanisms and procedures were suggested to propel change that benefits the hospitals and nurses in general. The new BSR-based work behaviour is expected to mould medical staffs in accordance with the dynamic environment and stay with the latest developments in the field of healthcare.

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