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Frequently Asked Questions

How should I interpret Turnitin's AI writing percentage and false positives?
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AI detection scores under 20%, which we do not surface in new reports, have a higher likelihood of false positives. To reduce the likelihood of misinterpretation, no score or highlights are attributed and are indicated with an asterisk in the report (*%).

The AI writing percentage should not be the sole basis to determine whether misconduct has occurred. The reviewer/instructor should use the percentage as a means to start a formative conversation with their student and/or use it to examine the submitted assignment in accordance with their school's policies.

What does 'qualifying text' mean?
Our model only processes qualifying text in the form of long-form writing. Long-form writing means individual sentences contained in paragraphs that make up a longer piece of written work, such as an essay, a dissertation, or an article, etc. Qualifying text that has been determined to be likely AI-generated will be highlighted in cyan in the submission, and likely AI-generated and then likely AI-paraphrased will be highlighted purple.

Non-qualifying text, such as bullet points, annotated bibliographies, etc., will not be processed and can create disparity between the submission highlights and the percentage shown.

Jurisdiction and Authority Over the Quality Issue

Improving nurse communication during handoff necessitates oversight by those with jurisdiction over standards for clinical practice. For this reason, healthcare system leadership such as Nurse Managers, Quality Improvement Committees, and Chief Nursing Officers have a duty to implement handoff protocols (Hibbert et al., 2023). Hence, such roles have the potential to mandate compliance with standardized tools such as SBAR, and allocate resources.

In addition to the previously addressed internal control, regulatory agencies and accrediting bodies play a significant role. An example is where The Joint Commission emphasizes effective communication as a National Patient Safety Goal (NPSG), hence being a major focus during hospital accreditation reviews. Additionally, The Joint Commission's requirement for standardized handoff communication pressurizes institutions to comply with evidence-based practices (Wadhwa & Huynh, 2020). Similarly, professional organizations and state nursing boards such as the American Nurses Association (ANA) and the Agency for Healthcare Research and Quality (AHRQ) also drive change by setting practice standards on communication safety. Aligning policies across these levels therefore drive consistent improvement and enhances accountability in handoff communication.

Stakeholders and Decision-Makers

Addressing the quality of nurse handoff communication involves various stakeholders whose roles, advocacy, and decision shape patient safety outcomes. For this reason, bedside nurses are the most directly impacted stakeholders. This is because their input is essential in designing and refining sustainable communication tools. Consequently, engaging nurses in pilot testing and feedback sessions increases compliance and fosters a sense of ownership (Atinga et

al., 2024). Unit managers and nurse leaders are also decision-makers responsible for monitoring adherence to handoff procedures, while facilitating staff training. Their ability to implement policy changes and advocate for necessary tools directly affects the reduction of communication errors. Quality departments and hospital executives also serve as crucial stakeholders, especially when communication issues impact patient satisfaction, performance metrics, or lead to litigation.

Other important stakeholders include patients and families specifically in models such as bedside shift reporting, where they become active participants in care. Patients therefore benefit from consistent and clear communication, and have a vested interest in the safety and continuity of care transitions. On the other hand, health IT professionals may also be involved when electronic health records are used to implement handoff templates making them an indirect yet important set of stakeholders. Finally, external stakeholders such as insurance companies and professional nursing associations also influence the issues through reimbursement structures and policy enforcement. This is because such groups gain leverage in encouraging communication improvements when reimbursement is tied to outcomes such as adverse events or reduced readmissions.

Powerbases and Resources for Promoting Change

Several resources and organizational powerbases are necessary to drive improvement in handoff communication. One crucial powerbase is expert power demonstrated through the clinical expertise of senior practitioners and nurse educators. Such individuals are influential in leading change through providing formal training on standardized communication methods, and modelling best practices (Atinga et al., 2024). Another major source is legitimate power held by formal leaders such as policy-makers within the institution and nurse managers. Their authority

allows them to allocate time for staff training, and implement electronic documentation systems that support structured handoffs

The necessary resources include staff development programs such as communication workshops or simulation-based training to ensure competency in structured handoffs. Additionally, staffing support and time are also crucial since rushed or understaffed environments undermine proper handoffs (Ball & Griffiths, 2022). Finally, cultural support within the organization must be cultivated to promote psychological safety, where staff feel encouraged to ask questions, and clarify unclear information during handoffs. Ultimately, transformational leadership, shared governance models, and supportive teamwork reinforce a culture of continuous improvement in patient communication.

References

Atinga, R. A., Gmaligan, M. N., Ayawine, A., & Yambah, J. K. (2024). “It's the patient that suffers from poor communication”: Analyzing communication gaps and associated consequences in handover events from nurses’ experiences. *SSM-Qualitative Research in Health*, *6*, 100482. https://doi.org/10.1016/j.ssmqr.2024.100482

Ball, J. E., & Griffiths, P. (2022). Consensus Development Project (CDP): An overview of staffing for safe and effective nursing care. *Nursing Open*, *9*(2), 872-879. https://doi.org/10.1002/nop2.989

Blazin, L. J., Sitthi-Amorn, J., Hoffman, J. M., & Burlison, J. D. (2020). Improving patient handoffs and transitions through adaptation and implementation of I-PASS across multiple handoff settings. *Pediatric quality & safety*, *5*(4), e323. https://doi.org/10.1097/pq9.0000000000000323

Haliq, S. A., & AlShammari, T. (2025). Communication handover barriers among nurses and paramedics in emergency care settings. *BMC nursing*, *24*(1), 634. https://doi.org/10.1186/s12912-025-03286-4

Hibbert, P. D., Stewart, S., Wiles, L. K., Braithwaite, J., Runciman, W. B., & Thomas, M. J. (2023). Improving patient safety governance and systems through learning from successes and failures: qualitative surveys and interviews with international experts. *International Journal for Quality in Health Care*, *35*(4), 0. https://doi.org/10.1093/intqhc/mzad088

Janagama, S. R., Strehlow, M., Gimkala, A., Rao, G. R., Matheson, L., Mahadevan, S., ... & Newberry, J. (2020). Critical communication: A cross-sectional study of signout at the prehospital and hospital interface. *Cureus*, *12*(2). https://doi.org/10.7759/cureus.7114

Jimmerson, J., Wright, P., Cowan, P. A., King-Jones, T., Beverly, C. J., & Curran, G. (2021).

Bedside shift report: Nurses opinions based on their experiences. *Nursing open*, *8*(3), 1393-1405. https://doi.org/10.1002/nop2.755

Wadhwa, R., & Huynh, A. P. (2020). The joint commission. https://www.ncbi.nlm.nih.gov/books/NBK557846/