Bedside Shift Report Checklist

- ❑ Introduce the nursing staff to the patient and family. Invite the patient and family to take part in the bedside shift report.
- ❑ Open the medical record or access the electronic work station in the patient's room.
- ❑ Conduct a verbal SBAR report with the patient and family. Use words that the patient and family can understand.

  S = **Situation**. What is going on with the patient? What are the current vital signs?

  B = **Background**. What is the pertinent patient history?

  A = **Assessment**. What is the patient's problem now?

  R = **Recommendation**. What does the patient need?

- ❑ Conduct a focused assessment of the patient and a safety assessment of the room.
  - Visually inspect all wounds, incisions, drains, IV sites, IV tubings, catheters, etc.
  - Visually sweep the room for any physical safety concerns.
- ❑ Review tasks that need to be done, such as:
  - Labs or tests needed
  - Medications administered
  - Forms that need to be completed (e.g., admission, patient intake, vaccination, allergy review, etc.)
  - Other tasks: _____
- ❑ Identify the patient's and family's needs or concerns.
  - Ask the patient and family:
    - *"What could have gone better during the last 12 hours?"*
    - *"Tell us how your pain is."*
    - *"Tell us how much you walked today."*
    - *"Do you have any concerns about safety?'*
    - *"Do you have any worries you would like to share?"*
  - Ask the patient and family what the goal is for the next shift. This is the patient's goal — not the nursing staff's goal for the patient.
    - *"What do* you *want to happen during the next 12 hours?"*
    - Follow up to see if the goal was met during the verbal SBAR at the next bedside shift report.

Adapted from the Emory University Bedside Shift Report Bundle.

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