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 workstation 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.