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.

