CHRISTUS® Health
Shreveport-Bossier

Bedside Shift Reporting

Pre-Bedside Checklist:

1. Notify PT/Family 30-60 minutes Before Report Starts
2. Check Pain Score/Adm. Meds if Needed

Bedside Report Guide:

1. Introduce Oncoming Nurse & "Manage Up"
2. Verify ID Band
3. SBAR
4. Check IV Site
5. Verify if Correct IVF & Rate
6. Verify PCA or Epidural, Any Overdue Meds in Admin RX
7. Follow Lines to the Patient
8. **Look Under The Covers:**
   - Check Incisions
   - Dressings
   - Drains & Tubes
   - Foley
   - Ostomy
9. Check Other Equipment:
   - CPM
   - Wound Vac
   - Cervical Collar/Brace
   - Monitor
   - Transmitter
   - Fetal Monitor
10. Check Pain Score & Discuss Pain Mgmt.
11. Report Limitations, WB Status, Amb. Diet
12. Verify Trach Supplies in Room if Applicable
13. Restraints or Sitters Needed
14. Airborne or Contact Precautions
15. Discharge Teaching & Planning
16. Ask PT if they have Anything to Add
17. **Update White Board**
18. Thank You = Offgoing Nurse Says,
    "You're in good hands. Thank you for allowing me to care for you today."

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S *"I'm going home now. XXX will be your nurse today/tonight & is going to take great care of you."*

- State PT Name & Age
- Diagnosis, Code Status, Admit Status
- Doctors Caring for Patient

B *"I'm about to give report to XXX. Please listen so at the end you can ask any questions or fill-in any additional information that XXX will need to know to take great care of you today/tonight."*

- Give Brief & Pertinent Past Medical History; Explain Any Co-Morbidities or Events that Led You to This Hospitalization or that are having an Effect on the Patient at This Moment in Time

Admitted For...

Pertinent History...

Pertinent Labs/Tests (Completed or Planned for That Day & Results)

Current Therapy (Meds, Treatments, Monitoring, Dressings, Drains, Tubes, Oxygen, Pulse Oximetry, IV Sites (PICC, CVC Lines, Ports)...

Current VSs...

Pain (Rating, Drug, Last Does, Follow-Up Assessment, Include PT in Discussion)

Other Clinical Info (PCA/Epidurals - 2 Nurses Must Check, Activity Level)

Special Needs (Precautions, Isolations, Fall Risk, Dialysis, Fluid Restrictions)

Consults (Physicians, Social Worker, Case Manager, Wound Care, Dialysis, Etc.)

Teaching Needs (Diabetic, Wound Care) Ask the Patient!

Discharge Plan & Needs (Ask the Patient!)

A

- Inform the Oncoming RN of what You have Assessed &/or Noted During Your Shift
- Provide a Review of Systems (ROS)
- Mention All Tubes, Lines & Drains
- Include Any Information or Tasks that You have Completed in the Patient's Care
- Mention what the Oncoming RN will Need to Complete or Follow-Up On

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R I Suggest That You (What Needs to be Followed-Up on That Shift, PT Goals, Etc.)

- Identify the PT & Family's Needs or Concerns
- Ask the Patient & Family what the Goal is for the Next Shift. This is the Patient's Goal - Not the Nursing Goal. "What do you want to happen during the next 12 hours?"

"Is there anything else XXX needs to know about caring for you today?"

T Thanks - To the Patient

Inform the PT of any diagnostic testing to be completed & what they can expect during your upcoming shift. We are here to provide you **very good** care!

"You're in great hands. Thank you for allowing me to care for your today."

S = Situation ***B*** = Background ***A*** = Assessment
R = Recommendation ***T*** = Thanks

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Bedside Report
Unit Observation and Coaching Documentation Form

Unit _____ Date _____ Shift _____

Observation of off-going nurse:	Expected Behaviors Performed:	Y	N	Not Applicable
1. Introduction	Professional introduction of on-coming nurse			
2. Use of SBAR	Followed SBAR communication technique, avoided medical jargon			
3. Safety scan	Verified ID band and other armbands needed, such as allergies			
	Checked bed alarms and other pertinent alarm settings			
	Checked IVs, PCAs and other devices			
	Verified Braden scale for pressure ulcers			
	Validated infection control procedures			
	Validated mobility or ambulation limitations			
	Visually scanned for obvious safety hazards, such as spills			
	Verified presence of needed equipment, such as ambu bags and suction			
4. Patient/Family involvement	Did the nurse ask the patient and/or family if they had any questions or comments?			
5. Thank you	The nurse thanked the patient and / or family			

If report was not done at the bedside, what reason was given? _____

_____

Is staff follow-up needed? Yes / No **If yes, action plan (check all that apply):**

Action	Date Completed	Comments or Follow-up
☐ Discuss one on one with staff nurse		
☐ Discuss issue (s) at next staff meeting		
☐ Discuss with other nursing leaders and/or Chief Nursing Officer (for instance, have issues become a trend which need to be addressed across the organization?)		

Nurse Manager/Preceptor Signature: _____

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Competency Validation Checklist
Bedside Shift Report

Name: _____ Date: _____

For successful demonstration of competency,
All * items must be demonstrated or verbalized as appropriate.
At least 85% of all items listed must be demonstrated or verbalized as appropriate.

❖ **COMPETENCY STATEMENT:** The nurse demonstrates competency in performing bedside shift report when communicating patient status at the change of shift, addressing the essential elements of the report and eliciting patient input regarding their care and goals for the shift.

Skill	Check if Demonstrates Adequately
Professionally introduces oncoming nursing to patient and family.	
Utilizes electronic record in report.	
Invites patient to provide input during the report	
Conducts verbal SBAR with patient and family 1. Establishes the patient's current situation. 2. Provides relevant background, focusing on recent trends appropriate to the patient's care, e.g. telemetry rhythms, labs, etc.. 3. Provides the most pertinent problems being addressed by the health care team 4. Provides the specific immediate needs being addressed during the shift	
Addresses patient safety considerations 1. Verifies armband with oncoming nurse 2. Validates latest fall risk score and verifies interventions 3. Verifies placement dates for central line and indwelling urinary catheter and plans for removal 4. Verifies latest Braden score for pressure ulcers 5. Verifies bed alarms and other pertinent alarms 6. Validates the presence and functionality of equipment 7. Reports any infection control concerns 8. Reports any ambulation or mobility safety concerns or use of special equipment 9. Visually scans for obvious safety hazards 10. Invites patient/family input	
Addresses medication and nutritional considerations 1. Checks IV site with oncoming nurse 2. Using eMAR, validates IV medication dose/rate, remaining volume. 3. Reports on any overdue medications or reasons why scheduled medications were omitted. 4. Verifies any dietary considerations or changes	
***Visually inspects with the oncoming nurse*:** 1. Catheters, tubing, PCA, epidural 2. All wounds, incisions, drains, dressing, ostomy, pressure ulcers 3. Ensures the functionality of other equipment, e.g. wound vac, suction.	

Pain management 1. Asks patient to rate pain using appropriate pain scale 2. Reports pain medication, dose and last administration to oncoming nurse 3. Validates the efficacy of pain medication with the patient	
Tasks to be done during the shift 1. Conveys information regarding lab tests, treatments or specific medications that are scheduled for the shift	
Identify patient/family needs and concerns 1. Questions patient/family regarding what could have gone better during last shift, ambulation, safety concerns or other concerns	
Asks patient/family about their goals for the next shift.	
Thanks patient/family for participating in rounds and for allowing you to care for them	
Update the white board in the patient room with pertinent information to communicate the plan for the shift	
TOTAL NUMBER OF ITEMS DEMONSTRATED ADEQUATELY.	
MINIMUM NUMBER OF ITEMS REQUIRED FOR THIS SKILL.	24 of 30

Remediation Plan:_____

Validator Initials, Signature, Title: _____

Date_____

Bedside Shift Report: Script Key Elements and Practice Tool

Bedside Report Script Elements	Script
Introduce the oncoming nurse to patient and family. Professionally introduce your colleague!	"Mr. or Mrs. _____, my shift is ending but this is (**on coming nurse's name and title**) and he/she will be caring for you next shift. (**On coming nurse's name and title**) has been a nurse at CHRISTUS (**hospital name**) for ____ years and will give you great care today."
Open electronic work station for review during bedside report.	"I'm opening your chart to check important aspects about your care. Please feel free to add anything you'd like (**nurse name**) to know or ask us any questions. We want to make sure we've covered everything for your safety."
Conduct verbal SBAR with patient and family: **S: Situation** • What's going on with the patient? • What are the current vital signs? **B**: **Background** • What is the pertinent patient history? Focus on past 24-48 hours, e.g. telemetry rhythms, finger stick glucose readings ● **A: Assessment** • What is (are) the most pertinent problems to address? **R: Recommendation** • What are the most immediate needs that are being addressed?	**S**: "Mr. or Mrs. _____ has been a patient here for [**treatment/surgery**]. The last sets of vital signs are _____." (**can mention how long the patient has been in the hospital or how many days post-op**) **B**: "Over the last day/couple of days, (**brief description of trends. Include telemetry, finger stick blood glucose trends, significant lab trends, diagnostic tests**)" **A**: "The main issues the doctor has been addressing include," (**e.g. wound healing, pain management, mobility, nutrition, respiratory care**). **R**: "We've been focusing our attention today on," (**e.g. pain, ambulation, blood administration)**

Patient Safety	*Script*
● Verify ID band and other armbands	"Mr. /Mrs. _____, we are going to check your armband and we are going to make sure everything you need in your room is here and in good working order. Has everything been working for you?" (**Ensure any needed equipment is in place and is operable**)
● Validate latest fall risk score and verify interventions	Report on latest fall risk score and interventions
● Verify placement dates for any central lines and indwelling urinary catheters and plans for removal	Report placement dates for central line and indwelling catheter and verify the plans for removal
● Verify Braden score for any risk for pressure Ulcers	Report the latest Braden score for pressure ulcers
● Verify bed alarms and other pertinent alarm settings ● Verify presence of needed equipment, e.g. ambu, suction ● Validate infection control precautions ● Validation mobility or ambulation limitations	Report any infection control precautions in place, ambulation limitations, safety needs such as a gait belt or lifting device.
● Visually scan for obvious safety hazards, e.g. spills, etc.	Scan the room for any obvious safety hazards.
Medications/Nutrition	
● Check IV site, IV fluids, verify contents, rates, volumes	"Mr. or Mrs. _____ has an [IV/central line/PICC/port] in the (**location of site**). Let's take a look at the site." "He/she is receiving [**note IV medication, check contents, rate and volume remaining**]." (**Report on the patency of the site or any concerns regarding the patency**)
● Check eMAR for overdue medications or those not administered	"I see on the eMAR that everything is up to date on medications [**or note that a medication is overdue or a dose was omitted and report the reason**]."
● Check diet considerations	
Visually inspect (pick up the covers)	
● Any catheters, tubing, PCA, epidural catheters ● All wounds, incisions, drains, dressings, ostomy, pressure ulcers	"Mr. or Mrs. _____, I'd like (**nurses name**) to take a look at your [**dressing, incision, drain**] so I am going to lift the covers a little so we can see it."

Visually inspect (continued)	**Script**
● Any other equipment utilized in patient's care, e.g. wound vac	"While we are looking, let's make sure that all the tubing and catheters are draining well and working." (**trace all lines, tubing, catheters from the patient to the source**)
Pain management	
● Check pain score with the patient	"Mr. or Mrs. _____, on a scale of 1-10, how would you rate your pain?"
● Review pain management therapy	"Mr. or Mrs. _____ has been receiving [name of medication, dose and frequency] for pain. The last dose was received at [**report time.]**
● Validate efficacy of therapy	"Mr. or Mrs. _____, do you feel you are getting adequate relief from the medication?"
Review tasks that need to be done on this shift	
● Laboratory tests, respiratory treatment, dressing changes, particular medications	"There is a scheduled [**lab test, respiratory treatment, dressing change or other specific task**] for the next shift that is due about [**mention time**]." (**Report as well if there is nothing specific scheduled for the shift**)
Identify patient/family needs and concerns	
● What could have gone better during the last 12 hours?	"Mr. or Mrs. _____, I think we've talked about the issues ____needs to know but we'd like to hear from you about anything you might like to tell us." "What could have gone better during the last shift."?
● How much have you walked/gotten out of bed today?	"About how much did you walk [**or get out of bed**] today?"
● Do you have any concerns about safety?	"Do you have any concerns about your safety?"
● Do you have any worries you'd like to share	"Is there anything else that concerns you about what's planned for the shift?"

Ask the patient/family about their goal for the next shift	***Script***
● What would you like to see happen during the next 12 hours?	"What would YOU like to see happen during the next shift?"
● Follow up to see if goal was met during next shift report	"Please let us know if we met your goal during our next shift report."
Thank patient/family for participating in report and for allowing you to care for them	"Mr. or Mrs._____, we appreciate you working with _____ and me during shift report. We thank you for giving us the opportunity to care for you."
Update the white board in the patient's room with pertinent information	"I'm going to update the white board with the latest information so the team can take excellent care of you and help you meet your goals."

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