Bedside Shift Report

Improves Patient Safety and Accountability

To help prevent "dropping the baton" during change-of-shift, health care providers are moving shift reports to the bedside. There are many benefits but the most important one is "patient safety".

Although bedside shift reports can vary from facility to facility and even unit to unit, successful implementation provides a real-time exchange of information between the incoming and outgoing care providers and the patient and family. Many providers have developed their own communication tool for change of shift at the beside. A method called "SBAR" can also be used effectively *(see sample on reverse side).*

It is also helpful to let the patient and family know ahead of time that, with their permission, change of shift occurs at the bedside – what it is, why it is important and how their privacy is protected.

"There is a troubling lag-time between presentation of evidence and implementation of practice. Effective handover is a National Patient Safety Goal of Accreditation Canada. We've known for a long time that face-to-face handover at the patient's bedside increases patient safety and transparency – let's just do it!

A. Vanderklaaux,
Clinical Safety Leader, RAH

"If YOU were the patient, wouldn't you want to know? Who is more interested in safe patient care than the PATIENT themselves!"

Respiratory Therapy Department, RAH

Benefits:

- Patient safety.
- Builds trust as the patient is part of the care team.
- Patients are seen sooner and more holistically.
- Providers are better able to prioritize patient care.
- Staff, patient, and family know the treatment plan.
- Patient and family information aids diagnosis and treatment.
- Mentoring opportunity for new nurses.
- Educational opportunity for everyone involved.
- Increased patient satisfaction.
- Aids communication between care providers and between care providers and the patient and family.
- Less time – only takes 3 to 5 minutes.

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Using SBAR for Bedside Shift Report

S = Situation	B = Background	A = Assessment	R = Recommendation

S	**Outgoing Provider** • Complete shift – "I am leaving now and Jane will be taking care of you next shift. Jane has… so I am leaving you in good hands." **Incoming Provider** • Introduce self using NOD (name, occupation and duty). Updates whiteboard (if available). Ask patient to state their name and date of birth, while checking the patient's ID tag.
B	**Outgoing Provider** • Include the patient – "It is time for me to give my report to Jane and we would like to do this at your bedside so that you can be included. This will give you a chance to ask questions and to add information, which will help Jane to take the best possible care of you. Because we need to do this for all of our patients, it is a quick report – it will only take two to three minutes. If you need more time, Jane will come back later. " **Incoming Provider** • "Do we have your permission?"
A	**Outgoing Provider** • Provide information – provide a brief status update including the patient's primary complaint and what treatment/medications have occurred to date with a focus on the last shift and any follow-up that needs to occur. **Incoming Provider** • Review chart/check documentation. • Conduct a quick physical exam (if necessary) and check all IV sites/pumps for accuracy. • Assess patient's pain using a pain scale.
R	**Outgoing Provider** • Review all orders and the plan of care with incoming provider (tests, treatments, medication therapy, IV sites/meds). • Include relevant medications that have been ordered and any ancillary or support services; e.g., physiotherapy, radiology. • Ask the patient, "Do you have any questions? Is there anything else Jane needs to know at this time?" **Incoming Provider** • Validate treatment orders/plan of care. Asks outgoing provider and patient/family if they have any additional comment/questions. • Thank the patient. Checks to ensure the patient understands the plan of care and is comfortable.

This Practical Wisdom Adapted from:
Baker, S., & McGowan, N. (Section Ed.). (2010). Bedside shift report improves patient safety and nurse accountability. *Journal of Emergency Nursing*, 36(4), 355-358.
Griffin, T. (2010). Bringing change-of-shift report to the bedside: A patient- and family-centered approach. *Journal of Perinatal and Neonatal Nursing*, 24(4), 348-353.