

BSR10: BEDSIDE SHIFT REPORTSM “HOW TO” AND TIPS

1. **EDUCATE PATIENT:** Prior to Bedside Shift ReportSM, advise and educate the patient about Bedside Shift ReportSM – During your last hourly rounds, say, “We will be doing Bedside Shift ReportSM very soon, is there anything I can get you while I am here? We will be talking about your condition and your progress at this time. Since we want to maintain your privacy, if you have visitors at the time we come in, would you like me to ask your visitors to step out?”
2. **COMMUNICATION FRAMEWORK:** Use the SBAR (Situation-Background-Assessment-Recommendation) communication technique provides a framework for communication between members of the health care team. SBAR is an easy-to-remember and concrete mechanism useful for framing any conversation, including those held in front of the patient. This technique facilitates an easy, focused way to set expectations and, relay important information. A strong method of communication is essential for developing teamwork and fostering a culture of patient safety.
3. **INTRODUCTIONS:** Introduce the on-coming nurse. Whenever possible, manage the nurse “up”.
4. **PATIENT DISCUSSIONS:** Discuss, with the patient and nursing team, the patient’s condition, tests, procedures and purposes of the tests/procedures. Become familiar with these tests or procedure to properly advise or answer questions for the patient. If a new diagnosis (i.e. cancer) or test results occurs, give the information that the patient is aware of during Bedside Shift ReportSM. You can give additional information to the next shift after the Bedside Shift ReportSM or point to an item on your paper. Be sensitive to the location of sharing this information to protect patient’s privacy.
5. **EQUIPMENT AND SUPPLIES:** Check the equipment and supplies in the room – IV’s, monitors, etc.
6. **PATIENT NOT IN ROOM:** What to do if the patient is “off the unit” or asleep:
 - Do not wake the patient up, unless the patient has requested to be awake during Bedside Shift ReportSM. This information can be obtained during hourly rounds, or the development of the patients’ “What’s Important to Me Today” items.
 - On-coming nurse will observe the patient and quietly check equipment.
 - Later, the on-coming nurse will review the “Bedside Shift ReportSM” information to the patient/family if they have missed it.
 - Off-going nurse will give a verbal report to the on-coming nurse if the patient is “off the unit” along with estimated time of patient’s return to the unit.
7. **NOT ABLE TO PERFORM:** If there is a code or crisis at shift change, the on-coming nurse will still go – room by room – to introduce self and check patients.
8. **VISITORS:** If visitors are in the room, explain that you are doing the Bedside Shift ReportSM and ask them to step out. The patient may override this request by giving permission for the visitor to stay. This prevents placing the patient in an uncomfortable position if they prefer to maintain their privacy. It is best to discuss

with the patient prior to giving report. Discuss with the patient during the shift when patient is alone. You could say "When we change nurses, we will be talking about your condition and your progress this past shift. Since we want to maintain your privacy we recommend that your visitors step out for this report unless you prefer they stay. What would you prefer?"

9. **NON-COMPLIANCE:** If the patient is non-compliant, then the off-going nurse should not say "uncooperative" to the oncoming nurse. You could say "He/she was informed of ...but the patient chose to" "I have explained that if he refuses to use the walker for assistance, the likelihood of a fall and injury increases."
10. **FACTS:** Exclude opinions. Report is a time for facts. If a nurse is unhappy with the patient (or physician caring for the patient), the Bedside Shift ReportSM is not the time to vent. Criticism makes the nurse appear less credible.
11. **OFF-GOING NURSE:** Prior to leaving the room, the off-going nurse thanks the patient for allowing you to provide them care.
12. **EDUCATION OF PATIENT:** Educate your patients by advising them about Bedside Shift ReportSM at change of shift and look for the on-coming nursing team. Use key words from HCAHPS and your survey vendor such as "We use this as a time to explain your medications" "We want to keep you well informed" "It is important that you have an opportunity to participate in decisions about your care."
13. **MANAGE UP:** Take the time to manage up any additional staff caring for the patient.
14. **EDUCATION OF TEAM:** Educate the on-coming nursing team if they are float or registry personnel. Do not make this evident to the patient. Avoid comments like- This is Sharon – she doesn't normally work here..." If you don't know the float nurse ask them about their background and experience prior to going into the room so you can effectively manage them up. In areas where patients are have long lengths of stay and recognize nurses who are new, work with the team to be able to manage up nurses in a positive manner or have processes in place that will ensure the patient that core nurses will be available during any specific procedures where particular expertise is required.
15. **PRIOR TO BEDSIDE SHIFT REPORTSM:** Communicate to your patients before the Bedside Shift ReportSM starts. You could say "We will be doing Bedside Shift ReportSM very soon so is there anything you need at this time?"
16. **SENSITIVE ISSUES:** If the on-coming nurse has a question or needs clarification about a sensitive issue, wait until after Bedside Shift ReportSM and then ask the off-going nurse. Avoid putting a nurse "on the spot" in front of the patient and/or family