



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.



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