Bedside Reporting at Shift Change

In an effort to put patients central to all care activity information, many health care organizations are conducting nurse-to-nurse shift reports at the bedside in the presence of the patient. Bedside reports aim to avoid communication failures by exchanging real-time information at shift change (a most critical patient care interval). Bedside shift reporting is an innovative alternative to the traditional change of shift report that traditionally takes place in a unit hallway, at a nurses’ station, or via audiotape as it provides a live opportunity for questions and verification before valuable information is lost or overlooked.

What is bedside reporting?
The bedside report takes place between the outgoing and oncoming nurse next to a patient’s bedside at shift change. This meeting is intended to engage patients in exchange of real-time information at shift change, giving both the oncoming nurse and patient the opportunity to ask questions and verify important information about the patient’s history and care plan before the outgoing nurse leaves.

Why is bedside reporting beneficial?
Bedside reporting puts patients at the center of care. Further, through bedside reporting at shift change, both the patient and oncoming nurse will have the opportunity to ask questions, express concerns, and to convey goals for the patient – steps that increase patient safety. (By giving both the patient and oncoming nurse the opportunity to ask questions, information that might be lost or overlooked during traditional shift change is retained.)

Bedside reporting allows organizations to address the National Patient Safety Goals established by the Joint Commission that require hospitals to encourage patients’ active involvement in their own care as a patient safety strategy (goal 13) and to aim to improve the effectiveness of communication among caregivers (goal 2).

Organizations implementing bedside reporting are creating patient-centered care cultures giving patients a more active role in their care. When conducted successfully, bedside reporting increases patient safety, improves teamwork between care providers, and promotes transparency and shared responsibility for patients’ care.

Laying the Groundwork for Successful Bedside Reporting

MESSAGING
Messaging for nursing staff is a crucial component when laying the groundwork for successful bedside reporting implementation. Nurses must be provided with education about the benefits of reasons for bedside reporting in order to gain buy-in prior to implementation. Recruit the CNO and other nursing leaders to speak to all nursing staff about the benefits of bedside reporting, both for patients and for the nurses themselves, in a bedside reporting implementation kick-off meeting.

Nursing benefits include:
- Shared accountability by both shifts
- Reduced call light usage
• Nurses are able to leave work on time
• Reduced time for patient disclosure of information
• Reduced patient falls
• Better informed patients are less anxious and more likely to follow medical advice, making it easier for nurses to care for them
• Patients involved in their care are more satisfied
• Oncoming nurses visualize patients immediately and prioritize care for the shift
• Nurses are more prepared to answer physicians’ questions

Patient benefits include:
• Patients that are better informed are more likely to follow treatment plans
• Patients that are better informed are less anxious and stressed
• Patients recognize that the nursing staff works as a team and therefore are reassured of staff’s competence
• Patients can ask questions and add information to the discussion at shift report
• Patients are more likely to start treatment sooner

TRAINING
Once nursing staff have been educated on the benefits of bedside reporting, providing training for the unit that has been selected to pilot bedside reporting. Training must be conducted so that nurses may confidently carry out bedside reports. Nurses must be given the opportunity to learn about how to conduct a bedside report and what to say during the meeting. See Bedside Report Training Handout.

I. Use the section titled “How to Conduct a Bedside Report at Shift Change” to educate nurses on the bedside reporting process. Be sure to include and answer questions about common concerns surrounding bedside reporting as part of this training.

II. Give nurses the opportunity practice bedside reports. Put nurses into groups of three for a role-playing exercise. One participant takes on the role of the outgoing nurse, one participant takes on the role of the oncoming nurse, and one participant takes on the role of the patient. Distribute sample written scenarios that describe patients’ treatment plans, medications, symptoms, pain levels, etc. and allow the groups of three to practice the bedside report.

III. Give nurses a timeframe in which bedside reporting will begin on their individual units.

PILOT
Conduct a pilot bedside reporting program on one unit for six weeks. Gather success stories, challenges, changes to process, etc. during the pilot. Use metrics such as patient satisfaction survey data, call light usage, and recorded falls to monitor the positive changes that stem from the implementation of bedside reporting on this unit.

Once bedside reporting at shift change has been implemented on the pilot unit, use the chosen metrics and feedback from the nursing staff involved to make necessary changes to the program before implementing the program hospital-wide. Be prepared to adapt and make changes to the bedside reporting process based on feedback and data collected during the pilot before introducing this concept to additional units.

See Bedside Report Pocket Card.

IMPLEMENT
Implement bedside reporting hospital-wide only after a pilot program has been conducted, necessary
tweaks have been made, proper messaging has been conveyed, and nursing staff have been trained.
Move to one unit at a time and repeat the training originally given to the pilot unit (including any
changes that have been made based on the pilot unit’s feedback and chosen metrics). Invite nurses from
the pilot unit to speak to their experiences with bedside reporting when training additional units on the
bedside reporting process.

**SUSTAIN**
As challenges manifest during the initial months of bedside reporting implementation, hold nurses
accountable to ensure successful adoption of the new process. Unit managers should audit the
consistency of bedside reports at shift change by asking patients if they were involved at such meetings
(or at least given the option) every day.

Patients will expect to be involved in bedside reports at shift change as a welcome letter will have
explained the procedure to them, charge nurses will have discussed bedside reports with them, and
outgoing nurses will have notified patients and family members that bedside reports will be taking place
thirty minutes before each shift change (see the section “How to Conduct a Bedside Report at Shift
Change, PRE-WORK”). If bedside reporting is not happening consistently, work with individual staff to
identify opportunities for coaching and consider nurses’ suggestions that will help all nurses to adopt
the new process.

**EVALUATE**
Once bedside reporting has been adopted by all units, evaluate its effects on patient care and nurses’
workload periodically. Evaluation can take place by:

- Reviewing chosen metrics every quarter to identify units on which bedside reporting is positively
  impacting the patient experience, as well as units that are struggling to adopt the process
- Gather feedback by conducting a focus group with nurses
- Gather feedback by conducting a focus group with former patients

Based on evaluations, modify the bedside reporting program as needed and identify coaching
opportunities for units that are struggling to adopt the process.

**CELEBRATE**
Share the results of bedside reporting with staff. In nursing staff meetings, use storytelling to celebrate
success of bedside reporting. Invite nurses who’ve had positive experiences with bedside reporting to
speak to the larger group. Read patient survey comments about how bedside reporting has positively
influenced patients’ hospital stays. Recognize nurses who have championed bedside reporting publicly.

**How to Conduct a Bedside Report at Shift Change**

**PRE-WORK**
Some pre-work will be required prior to bedside shift report to ensure successful and efficient
implementation.

- Patients should be informed about bedside reporting and its purpose in a welcome letter upon
  admission. See Bedside Report Patient Letter.
- A charge nurse should discuss bedside reporting with patients so that there is a common
  understanding of the purpose of this meeting (i.e., patient-centered care) before the first
  change of shift during a patient’s stay takes place.

• The charge nurse should ask the patient to sign a bedside card that gives patients the option to participate in or opt out of bedside reporting if sleeping.
• Thirty minutes before shift change, outgoing nurses should notify patients and family members that bedside reporting will be taking place.
• Outgoing nurses should ask the patient who should be permitted to attend the bedside meeting.
• Outgoing nurses should check the patient’s pain score and administer medication if needed.
• Outgoing and oncoming nurses should hold a short huddle at the transition between each shift before bedside reporting begins. This huddle should be designated for sharing sensitive information, such as concerns about patients’ family or new diagnoses, that nurses are uncomfortable sharing with the patient at the bedside. It is important that only this sensitive information is shared during the huddle - the majority of exchanged information should be relayed at the patient’s bedside.

THE BEDSIDE REPORTING PROCESS
Bedside reporting pre-work ensures that patients’ basic needs are met prior to the bedside report so that bedside reports can be conducted quickly and efficiently.

POSITIONING
Form a triangle with the patient, the outgoing nurse, and the oncoming nurse at each point. Conducting a bedside report with nurses’ backs to the patient can do more harm than good.

INTRODUCTIONS
Both the outgoing and oncoming nurse should greet the patient by name. The outgoing nurse should introduce the oncoming nurse (and nursing assistant if appropriate). It will be important for the outgoing nurse to manage up – highlighting the oncoming nurse’s qualifications and strengths. For example, “This is Julie. She will be your nurse for the evening. She is very good with children and has extensive experience in pediatric care. She’ll take excellent care of your child and your family.”

WHITE BOARD
The oncoming nurse should update the whiteboard with his/her name, the name of the nursing assistant (if applicable), and his/her mobile number (if applicable).

PATIENT INVOLVEMENT
It is crucial at this stage in the bedside report for both nurses to encourage the patient to be involved, comment, and ask questions during the bedside report. Nurses can prompt patients with questions like, “Do you have any questions, Mrs. Jones?”, or “Have you noticed any unusual pain, Ms. Higgins?” Consider the patient’s common complications and symptoms and ask questions to help identify specific needs.

CLINICAL INFORMATION
The Joint Commission’s National Patient Safety Goal 2E requires a standardized approach to ‘hand-off’ communications. The outgoing nurse should use a standard communication technique and a shift change data template to relay clinical information to the oncoming nurse and patient. (Sensitive information will have been previously shared between nurses during a beginning of shift huddle.) All other information including medical history, code status, vital signs, pending lab results, fall risk status,
etc. should be discussed with the patient to promote transparency and a patient-centered culture. Nurses should be careful to explain clinical information in terms that patients can understand, avoiding medical jargon that the layperson won’t understand.

TIME FOR QUESTIONS
The 2007 National Patient Safety Goals established by the Joint Commission (2006) require hospitals to encourage patients active involvement in their own care as a patient safety strategy (goal 13). Before the bedside report ends, oncoming nurses should ask patients three questions, listening carefully to the responses.
1. What are your greatest concerns?
2. What are your goals for the next ___ hours?
3. Do you have any questions that I can answer before leaving the room?
Oncoming nurses should document the patient’s goals on the white board, in the patient’s own words.

Common Concerns

LENGTH OF REPORT
Concern: Nurses often struggle with supporting bedside reporting for fear that this nontraditional shift report will take longer and add to an already abundant workload. Nurses anticipate an increased workload and more time spent on shift change report when required to visit every patient’s room for a bedside report at shift change.
Solution: Bedside reporting cuts down on the time that it takes to exchange information at shift change as hourly rounding and pre-work should be done to limit the exchange of information at bedside report to concise, pertinent information (as outlined in the resource titled “Bedside Reporting Checklist”). As a result, patients are not being left alone for a long period of time (an obvious safety hazard) when shift reporting time is cut down to a minimum. Use success stories from nurse champions on the pilot unit to spread positive messaging about bedside reporting at shift change.

SHARING SENSITIVE INFORMATION
Concern: Nurses struggle with discussing sensitive information such as concerns about uncooperative family members, new diagnoses, etc. with the patient.
Solution: A huddle at beginning of shift is conducted to share sensitive information. Keep in mind, however, that the majority of the information relayed about the patient should be covered at the bedside with the patient.

PRIVACY
Concern: Nurses worry about violating HIPAA laws by openly discussing protected health information at the patient’s bedside where visitors, family members, or roommates might overhear sensitive or private health information.
Solution: When communication between caregivers and patient reveals protected health information, these communications do not violate HIPAA as they are considered incidental disclosures to providing patient care. However, covered entities must take reasonable measures to minimize the disclosure of this protected information. For example, talking in a low volume, pulling the curtain, asking the patient if they want a visitor to step out while discussing medical issues, etc.
However, these incidental disclosures typically relate to the issues at hand in caring for the patient and are significantly limited when compared to the information that is being shared in report between nurses at shift change. Typically during shift report an extensive medical history is shared as well as details of current treatment that would not necessarily be included in daily care communication with the patient. It is the details necessary during report that cause the debate about privacy concerns and bedside reporting.

Health care organizations must consult with their organization’s privacy officer or risk manager to determine if bedside reporting is appropriate or to create policies associated with bedside reporting if the decision has been made to implement bedside reporting. This is especially important for hospitals with semi-private rooms.

DAY SHIFT VS. NIGHT SHIFT

**Concern:** Patients may feel disturbed if nurses interrupt sleep to conduct bedside reports at shift change.

**Solution:** Hospitals have found that bedside reporting is most successful at the start of the day and evening shifts. Patients should be given the option to opt out of bedside reporting if sleeping using a bedside card that can be signed by the patient, indicating whether or not he/she would like to participate in the bedside report if sleeping.

**Metrics**

Use the following metrics to measure the success of bedside reporting:

**PRESS GANEY SURVEY QUESTIONS**

- How well the nurses kept you informed
- How well staff worked together to care for you
- Staff effort to include you in decisions about your treatment

**HCAHPS SURVEY QUESTIONS**

- HCAHPS: During this hospital stay, how often did nurses explain things in a way you could understand?
- HCAHPS: Overall Ratings question
- HCAHPS: Recommend this Hospital question

**Associated Resources**

- Bedside Reporting Training Handout
- Bedside Reporting Pocket Card
- Bedside Reporting Patient Letter
- Shift Change Data Template
- Bedside Reporting Bedside Card
# Bedside Report Training Handout

## Pre-Bedside Report Work

The purpose of the pre-bedside report checklist tasks is to take care of privacy concerns and pain needs prior to bedside shift report so that bedside shift report itself is efficient and brief.

- Notified patient and family (30 minutes before bedside report begins).
- Asked the patient who will be permitted to attend bedside report (patient, family, visitors, etc.).
- Checked pain score and administered medication if needed.

Use the Bedside Report Checklist to guide the discussion between the outgoing nurse, oncoming nurse, and the patient. Hospital leadership must determine the details of necessary clinical information to be exchanged.

- Form a triangle with the patient, the outgoing nurse, and the oncoming nurse at each point.
- Greet the patient by name.
- Outgoing nurse introduce the oncoming nurse (and nursing assistant if appropriate). Manage up by highlighting the oncoming nurse’s qualifications.
- Oncoming nurse (and nursing assistant if appropriate) greets the patient.
- Oncoming nurse updates the white board.
  - Oncoming nurse’s name
  - Nursing assistant’s name (if applicable)
  - Oncoming nurse’s mobile number (if applicable).
- Encourage the patient to be involved, comment, and ask questions while reviewing patient’s history and treatment plan at the bedside.
- Use a standard communication model (such as SBAR, ISBAR, The Three P’s, I PASS the BATON, etc.) and a shift change data template to relay important clinical information to the oncoming nurse.
- Oncoming nurse asks the patient three questions before leaving the room. **Listen carefully to the patient’s responses.**
  - What are your greatest concerns?
  - What are your goals for the next __ hours (duration of incoming nurse’s shift)?
  - Do you have any questions that I can answer before leaving the room?
- Oncoming nurse documents the patient’s goals, in the patient’s words, on the white board.
Bedside Report Pocket Card

Adjust font sizing and print on an index card that can be easily carried in staff’s pockets. Laminate the card for durability.

Pre-Bedside Report Work

*The outgoing nurse must be sure to complete the following tasks before bedside report at shift change begins.*

- Notified patient and family (30 minutes before bedside report begins).
- Asked the patient who will be permitted to attend bedside report (patient, family, visitors, etc.).
- Checked pain score and administered medication if needed.

Bedside Report Checklist

- Form a triangle with the outgoing nurse, oncoming nurse, and patient.
- Outgoing nurse introduce the oncoming nurse. Manage up.
- Oncoming nurse updates the white board with name, NA’s name and mobile #.
- Encourage the patient to be involved.
- Use a standard communication model and a shift change data template to relay clinical information to the oncoming nurse.
- Oncoming nurse asks the patient three questions before leaving the room. **Listen carefully to the patient’s responses.**
  - What are your greatest concerns?
  - What are your goals for the next ___ hours (duration of incoming nurse’s shift)?
  - Do you have any questions that I can answer before leaving the room?
- Oncoming nurse documents the patient’s goals, in the patient’s words, on the white board.
Bedside Report Patient Letter

Dear Patient,

Thank you for choosing (Hospital Name). In an effort to offer you more personalized care, our nursing staff conducts change of shift reports at the bedside. This means that when our nursing staff changes shifts at ___ a.m. and ___ p.m., they will meet with you in your room to introduce the oncoming nurse, to review your history and treatment plan, and to answer any questions you may have. Bedside reporting is being implemented on this unit to increase safety, to improve teamwork amongst our staff, to provide you with the opportunity to be more directly involved in your care, and to ensure that our nurses have slated time to answer your questions.

During our night shift, you may opt out of bedside report by signing the card located near your bed titled “Do Not Disturb”. The charge nurse will explain this option to you more thoroughly after admission.

Prior to each bedside report, your nurses will ask you who should be allowed to be present during bedside report at shift change. Please tell your nurse which members of your family or visitors may be present during bedside shift report so that we may protect your privacy. Keep in mind that sensitive information may be shared including your medical history, treatment plan, test results, diagnoses, etc.

We have begun bedside reporting at shift change to keep you informed about your care. We encourage you to be involved in these meetings by listening to the report, commenting, and asking questions along the way.

Thank you again for choosing (Hospital Name).

Regards,

Name

Title
# Shift Change Data Template

Use the template below to shape a communication plan for bedside report at shift change. Be sure to adapt this template to include appropriate information needed on the unit.

<table>
<thead>
<tr>
<th>Situation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
</tr>
<tr>
<td>Room Number</td>
</tr>
<tr>
<td>Admitting Physician</td>
</tr>
<tr>
<td>Admitting Diagnosis</td>
</tr>
<tr>
<td>Most pertinent issues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Admission</td>
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<tr>
<td>Discharge Date</td>
</tr>
<tr>
<td>Allergies</td>
</tr>
<tr>
<td>Code Status</td>
</tr>
<tr>
<td>Patient/Family Concerns</td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>Recent Interventions</td>
</tr>
<tr>
<td>Abnormal Labs</td>
</tr>
<tr>
<td>Vital Signs</td>
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<tr>
<td>Pain Status</td>
</tr>
<tr>
<td>IV</td>
</tr>
<tr>
<td>Drains/Tubes</td>
</tr>
<tr>
<td>Wounds/Dressings</td>
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<tr>
<td>Decubiti</td>
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<tr>
<td>Mental Status</td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td>Cardiovascular</td>
</tr>
<tr>
<td>GI</td>
</tr>
<tr>
<td>GU</td>
</tr>
<tr>
<td>Musculoskeletal/Fall Risk Status</td>
</tr>
<tr>
<td>Skin</td>
</tr>
<tr>
<td>Discharge Plan/Issues</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician/Ancillary Consults (Circle One)</th>
</tr>
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<tbody>
<tr>
<td>Psych</td>
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<tr>
<td>Surg</td>
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<tr>
<td>PT/OT</td>
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<tr>
<td>Speech</td>
</tr>
<tr>
<td>Wound Care</td>
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<tr>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last seen by physician (Date, Time)</th>
</tr>
</thead>
</table>

### Assessment

- What does the oncoming nurse need to know about this patient?
- What concerns do you have about this patient as you end this shift?
- What needs to be discussed to ensure a timely and seamless discharge?

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any pending treatment or tests?</td>
</tr>
<tr>
<td>What orders are not finished or require follow-up?</td>
</tr>
<tr>
<td>Follow-Up Care</td>
</tr>
</tbody>
</table>
Include Me

If I am sleeping, WAKE ME for bedside report at shift change.

☐ Check here if you would like to be included in bedside report at shift change.

Signed by:

__________________________

(Patient signs here.)
Do Not Disturb

If I am sleeping, do NOT wake me up during bedside report at shift change. I would prefer to rest.

☐ Check here if you wish NOT to be included in bedside report at shift change.

Signed by:

__________________________
(Patient signs here.)