Shift to Shift Report
A Journey Back to the Bedside

By Lynne Kijowski
Bedside Shift to Shift Report
Why?

- Joint Commission standards 2009 National Patient Safety goals: patient identification, improve communication among caregivers, and encourage patient’s active involvement in their own care.
- Collaborative model—patients are more involved in their care.
- Magnet redesignation
- Relationship based care is more patient focused. Patient and family must be a participating member in their plan of care.
- Patient safety
Relationship Based Care Delivery Model

- Relationship based care is a model of nursing care practice that UPMC St. Margaret recognizes as its core of nursing care expectations and achievements.
- Relationship Based Care (RBC) is the patient-focused care model chosen by UPMC St. Margaret as its Professional Practice Model (PPM) which places the patient at the center of all concerns.
- Return practice of nursing to basic purpose: caring and connecting with other human beings.
- Incorporates three crucial relationships.
  - Relationship between nurse and patient
  - Nurses’ relationship with coworkers
  - Nurses’ relationship with herself.
What is being measured

- Press Ganey question - How well nurses kept you informed.
- Overtime (previous studies show it will decrease).
- Nurse satisfaction (pre and post survey).
Bedside Report

- Definition - nurses providing shift-to-shift report at the patients bedside so the patient can be more involved in his or her care.
What is in it for me?

- Ability to visualize patients immediately and prior to shift.
- You are better prepared to answer physician questions.
- Real-time conversations.
- Self accountability and coworker accountability.
- More time (evidence that bedside report decreased overtime).
- Improved staff interaction/communication between all shifts.
What is in it for the patient?

- Assures the patient that staff work as a team and plan of care is shared.
- Patients can add to discussion.
- Brings patient close to the goal of decision making.
- Increased patient satisfaction.
- Better communication means increased patient safety.
Challenges

- HIPPA
- What if patient wants information you can not give them.
- Nurse not ready for report.
- Patients and family requests while giving report.
- Multiple nurses to report to.
Solutions

- Move am huddle to 8:30am.
- HUCS to take message for tests at shift change. HUC to tell primary nurse and float aide about stat tests at shift change.
- Phones are to be handed off at end of shift.
- Admissions after 7:00, 3:00, 11:00 will be the responsibility of the next shift.
Bedside Report Ground Rules

**Bedside Report Rules**

- Report times are:
  - 7:10
  - 3:10
  - 11:10

- Both oncoming and off going shifts should be prepared to report at these times. The only exception is a condition or emergent situation.

- Stay focused on the facts. Remember the off going shift wants to go home and the oncoming wants to get to work.

- Viewing the caredex should only take 5-10 minutes, please be ready for report at 10 minutes after the start of your shift.
Bedside Report Rules cont.

- Resource nurse will place 12 hour nurses at the end of team one and the beginning of team two. If at all possible 8 hour nurses should never be assigned to short hall. This will help make assignment more continuous and decrease the number of nurses that one nurse will have to give report to.
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| **Offgoing Nurse**-  
  “I am going home now. --------- will be your nurse for the next shift. |
| **Oncoming Nurse**  
  Introduce self-using AIDET (Acknowledge, Introduce, Duration, Explanation, Thank you)  
  Update white board  
  Check armband while asking patient to state his/her name and date of birth. |

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| **Offgoing Nurse**-  
  Give an update on patient’s chief complaint and what treatments/medications have been provided.  
  Update on any pending tests or treatments (i.e. lab/radiology)  
  Discuss any special needs (i.e. altered mental status, fall risk, isolation precautions) |
| **Oncoming Nurse**-  
  Ask any questions of offgoing nurse |

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| **Offgoing Nurse**-  
  Give explanation-“We are going to do a quick physical assessment together since we are changing shifts”.  
  Inform oncoming nurse of what you have assessed and or noted during your shift.  
  Include any information on tasks that you have completed.  
  Mentions what the oncoming nurse will need to complete or follow-up on. |
| **Oncoming Nurse**-  
  Review EMAR  
  Conduct a quick physical assessment and check all IV sites/pumps for accuracy.  
  Assess patients pain using a pain scale |

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| **Offgoing nurse**-  
  Review plan of care with oncoming nurse (tests, treatments, medications.  
  Include any relevant medications that have been ordered and any ancillary or support services that are working with the patient such as respiratory therapy, radiology, social service, PT, OT, etc.  
  Ask the patient “Do you have any questions? Is there anything else the nurse needs to know at this time? |
| **Oncoming Nurse**-  
  Validate plan of care. |

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| **Thank the patient**  
  **Offgoing Nurse**-Prior to leaving the room, ask the patient the following  
  In your **pain** under control?  
  Do you understand your **plan of care**?  
  Do you know what you are waiting for and what will happen next?  
  Do you have any **concerns** we can address?  
  **Use closing key words**  
  **Offgoing nurse**-“--------- will take very good care of you. Thank you for allowing me to care for you today”.  
  **Oncoming nurse**-“Is there anything you need right now? I’ll be back to check on you in about an hour.” |