Bedside Shift Report

Implementation Time Line

- **Month 1**
  - Literature review
  - Survey nurses and patients
  - Review safety initiatives

- **Month 2**
  - Data to Unit Council for review and analysis
    - Shared baseline metrics of survey results
    - Presented Bedside Shift Report trials/outcomes and safety information
    - Identified perceived challenges
  - Unit Council were decision makers
    - No negativity allowed!
    - Brainstormed about the template
  - Mandatory Unit meetings
    - Introduced the general template
    - Looked at perceived challenges
    - Determined Go-live date

- **Month 3**
  - Go live
  - Observed all hand-offs, all shifts
  - Continued QA monitors based on template
  - Continued surveys of patients
  - Open communication and feedback was key
  - Unit Council reviewed feedback and edited template
  - Changes reported back to unit

- **Month 4**
  - Celebration
  - QA moved to random monitoring
  - Continuing collection of patient feedback

- **Month 5**
  - Nurse survey
  - Follow up with staff at unit meeting
  - Continued evaluation process

- **Month 6**
  - Continued evaluation of template vs. kardex use for report
  - Incorporated template elements into electronic kardex
  - Review of Press Ganey and HCAHPS
Dear Patient,

Welcome to Memorial Hospital and Health Care Center.

Thank you for choosing Memorial Hospital. In an effort to offer you more personalized care, our nursing staff offers a change of shift report at the bedside. Bedside reporting is being done on this unit to provide you with the opportunity to be more directly involved in your care, promoting safety, and to ensure that our nurses have time to answer your questions.

We encourage your input and hope you will ask any question you may have during bedside shift report. This will allow us to provide you the very best care. This may occur in the early morning and in the late night hours.

Prior to each bedside report, your nurse will ask you who should be allowed to be present during this time to protect your privacy. Keep in mind, sensitive information may be shared including your medical history, treatment plan, test results, diagnoses, etc.

We hope you find this opportunity beneficial. We welcome any comment to help make this even better.

Thank you again for choosing Memorial Hospital and Health Care Center.

The Nursing Staff
Bedside Shift Reporting Process:

1. Complete the last “hourly round” approximately 1 hour before shift change:
   - Nurses (and CNAs on Post Surgical) are encouraged to perform a final hourly rounding with each patient to ensure the “four P’s” (pain, position, potty, and proximity of needed items) are all taken care of.
   - The nurse is also encouraged to notify the patient/family that the shift is about to change.
   - Be prepared to begin report within 10 minutes of arrival of next shift.

2. Oncoming nurses will obtain Kardexes for assigned patients and review (goal: finish review within first 10 minutes of the shift).

3. Locate off-going nurse to begin bedside report process as follows:
   1. Off-going nurse introduces oncoming staff to patient/family and explains that report will begin. Visitors should be excused at this time unless patient/parents give permission for their presence.
   2. On Post Surgical-patient whiteboard is updated with nurse/CNA names, daily patient goals, projected discharge date are listed on whiteboard.
   3. Patient is encouraged to participate in report as desired and will be given time to ask questions at the completion of report.
   4. Safety check: Bubble tops closed, side rails up, halo tag in place, ID band, allergies.
   5. Report (using template) is given.
   6. At conclusion, patient is asked if they would like to add any information or if they have questions. Patient is asked to “teach-back” plan of care for the shift.
   7. Patient is informed that nurse will be receiving report on other patients and approximate time frame for return is offered.

*Confidential or sensitive information should be communicated prior to bedside report in treatment room or other private area.
Report Content:

- Diagnosis
- Past Medical History
- Pertinent vital signs
- Abnormals from assessment
- I&O
- Pending labs or procedures (reinforce to family MD will review results)
- Last prn meds or treatments given
- Any change in patient condition during shift
- Plan of care/goals for next shift
- Update on education given to patient/family
- Confidential information to be given in treatment room (i.e. lab or test results, family issues, behavioral issues)
CNA Shift Report:

- Obtain patient assignment, care information from Meditech
- Enter phones into computer by 10 minutes into shift.
- Meet at nurses station with off-going CNA (if any) to receive verbal report
- CNAs primary responsibility will be addressing patient needs/call bells until the nurses finish bedside report.
- After nurses finish report, touch base with nurse to identify pt care priorities.
- Introduce yourself the first time you enter your patient’s room and update the whiteboard with name/length of your shift
- Complete final hourly round on all patients in the last 1 hour of your shift. It is important to address the 4 Ps:
  - Potty
  - Pain
  - Positioning (reposition)
  - Proximity (of call bell/needed items)
- Remember to meet any oncoming CNA(s) 10 minutes into the shift to give report.

I WANT YOU (AND YOUR IDEAS!) FOR CNA SHIFT REPORT

Please put your feedback (good and bad) and ideas you have to improve the process on the conference room board!
1. Begin charge nurse report on the hour (0700, 1500, 1900, 2300) so charge nurse with team will ideally be ready to give/receive bedside shift reports beginning at 10 past the hour.

2. Use census sheet to obtain list of patients.

3. Move down list to identify information pertinent to charge nurse for each patient:
   a. Planned discharges/admissions
   b. Planned procedures or tests
   c. Complicated patients
   d. Abnormals (total hip blood transfusions, etc.)
   e. Significant changes in condition – i.e. patient with decreased O2 sats during noc, any RAT team calls, etc.
   f. Other pertinent info: safety issues (i.e. disoriented/confused, one-on-one assignments), special equipment (traction, blood warmer), etc.

4. Upon completion of report, identify priorities and any potential safety concerns on unit for the shift.

5. If Charge without a team, assist with call bells and patient needs during period of bedside shift reporting to limit interruptions in report process.

Charge nurse priorities:

1. To stay current on admits and discharges
2. To touch base with all nurses during shift to stay informed of nurse workloads and significant changes in patient condition or significant events in plan of care for next shift (i.e. blood transfusion or planned surgery)
3. To make assignments appropriately based on:
   • the number of patients/staff (staffing grid)
   • staff competency
   • the condition and intensity of care required for patients
4. To adjust staffing as patient care needs change and ensure related necessary phone calls are made (i.e. on call notifications, etc.)
5. To assist with basic unit care functions as able based on priority
POST SURGICAL SERVICES – NURSING SURVEY

Patient Satisfaction

Our nurses help keep the patient informed about their current medical condition and progress.

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<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
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Our nurses use printed educational materials to teach the patient about their condition and plan of care.

<table>
<thead>
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<th>Never</th>
<th>Sometimes</th>
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Our nurses include patients in planning their care.

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<th>Never</th>
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Our patients have all the information they want about tests and procedures.

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Our patients know what the plan of care throughout each shift will include.

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Patients that are being discharged to home leave the hospital prepared with the knowledge and skills needed to care for themselves at home.

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POST SURGICAL SERVICES-PATIENT SURVEY  
BEDSIDE SHIFT REPORTING

Please circle your response:

<table>
<thead>
<tr>
<th>I feel informed about my current medical condition.</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1=Never</td>
<td>2=Rarely</td>
<td>3=Sometimes</td>
<td>4=Almost Always</td>
<td>5=Always</td>
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<table>
<thead>
<tr>
<th>The nurses share information about my condition and progress.</th>
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<th>I have the information I want about my tests and procedures.</th>
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<th>I know what to expect and what the plan for my care each day will include.</th>
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Before my nurse leaves from her shift, I always know who will be taking over for her on the next shift.
Yes _______   No _______

I feel the nurses who care for me always communicate well with me.
Yes _______   No _______

I feel the nurses who have cared for me always communicate well with each other.
Yes _______   No _______

I would like to be more involved in the plan for my care.
Yes _______   No _______

I sometimes wish I knew more about my condition, tests or procedures.
Yes _______   No _______

I always feel safe on this nursing unit.
Yes _______   No _______