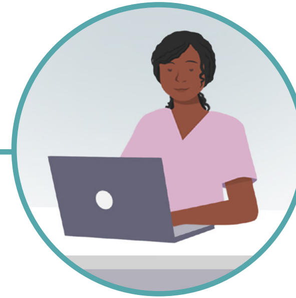
CHECKLIST FOR BEDSIDE SHIFT REPORT

A Bedside Shift Report:

- Occurs in inpatient healthcare settings when a change of staff occurs
- Is done on every client in a nurse‘s care
- Is often done in priority of the most critical to the least critical patient

Knock on the client‘s door before going into the client‘s room

Introduce yourself and your colleague and explain what you are doing



Open the EHR if there is one in the room

Conduct a verbal hand-off report

A Good Bedside Shift Report Includes a Client‘s:

- ✓ Identifying data (name, date of birth, room number)
- ✓ Pertinent medical history, e.g. medications, allergies, and health conditions
- ✓ Key events and plan of care
- ✓ Physical and mental condition from a recent assessment
- ✓ Baseline condition
- ✓ Completed, immediate, and upcoming interventions, procedures, safety needs, and education

NURSING NOTES:

- If time permits, you can complete a brief focused assessment with the other nurse before their shift ends to discuss any urgent client needs.
- Sensitive or confidential information may need to be provided in addition to the bedside report.

NOTES