Effective bedside shift reporting can decrease adverse events and patient care errors (U. S. Department of Health and Human Services, 2017). Communicating accurate and critical information from one nurse to the next is required for appropriate continuity of patient care. Patients’ participation in shift reporting between nurses can improve the safety of the nursing care provided.

Bedside shift report handoffs, like traditional shift reporting, can lack standardization, be unstructured and communicated haphazardly. This lack of standardization can contribute to transmitted information between nurses that varies in quality and may lead to communication failures. Such communication failures can compromise patient safety (Phillippe, 2017), and lead to errors in patient care.

During the handoff many oncoming nurses take notes about patients on paper worksheets printed out about each patient. The accuracy of the data nurses record on the patient worksheets is important for providing safe and effective patient care. A larger study exploring bedside shift reporting was conducted, with this poster reporting one arm of the study.

To examine the bedside shift report process, a descriptive study was conducted at an acute care hospital with over 400 beds located in the Southeast region of Texas. Nurses participating in the study were asked to compile a change of shift report on a simulated patient case, just as nurses do for actual patients in preparation for shift changes. Participants compiled data for a shift report on the simulated patient case to demonstrate what data the nurses identified as being important to share in a bedside shift report.

A panel of three expert clinicians with at least a BSN degree and over five years of clinical experience identified as being important to share in a bedside shift report. The printed patient worksheets contained all of the critical elements about patients’ identify information.

Critical information about patients’ diagnoses was partly addressed on the patients’ printed worksheets, as their reason for admission was included and chief complaint. Nurses needed to write additional information on the worksheets, especially information about past medical history, diagnostic tests, and review of body systems. Advanced directives information was printed on the patient worksheets.

Printed current status information on allergies, diet, isolation precautions, and fall risk were included. Most nurses did not add data on mobility, special needs, equipment, anticipated problems, issues to monitor closely, pending tests, or discharge planning.

The findings have implications for nursing practice and patient safety. Critically important patient information needs to be communicated during bedside shift reporting for safe patient care. A simulated patient case can be used to analyze if nurses identify the critical information to communicate during the bedside shift hand off.