

**ST. DAVID'S HEALTHCARE**  
**COMPETENCY NAME: Bedside Shift Report**

Employee Name: \_\_\_\_\_ Facility / Unit: \_\_\_\_\_

DESIRED OUTCOME	RESOURCES
Understand and perform, as part of regular assigned duties, the principles and tasks associated with staff bedside reporting.	Facility policy and procedures, Institute for Learning website, Studer Group website and videos
<b>PERFORMANCE CRITERIA</b>	
<b>Evaluation Methods: V=Verbalizes; D=Demonstrates; O=Observes; S=Simulates; T=Test; H=HealthStream; OL= Online; N/A=not applicable</b>	<b>VALIDATOR COMPLETES:</b>
The competence assessment process is tailored to meet the targeted population's age and developmental needs, as well as cultural, spiritual and personal values, beliefs, and preferences.	<b>Initial &amp; Date</b> <b>Eval Method</b>
1. Identify at least two predominant patient populations served on your unit.	
2. For this competency, identify how care is modified to accommodate the patient population specific needs: a. Verbalizes where to document this information b. Verbalizes other methods to communicate this information to healthcare team	
3. Demonstrate uses of AIDET, opening key words and/or actions to introduce the oncoming nurse, her skill set or experience, and explanation of and purpose of hourly rounding.	
4. Demonstrate use of staff bedside reporting on patient with oncoming nurse to include: a. tests b. procedures c. changes in medications d. changes in activity e. fall risk	
5. Demonstrates assessment of patient environment: a. clean room –linens clean, floors clean and clear, trash picked up, trays taken out of room etc b. patient can reach call light, phone, and bed controls as applicable	
6. Verbalizes the process for when the nurse receiving report has questions or need clarification on the patient's condition.	
7. Verbalizes the process for when visitors are in the room: a. permission from patient b. documents the permission	
8. Verbalizes the process for when the patient is asleep, non compliant or off the unit.	

**Final Validator to complete:**

Meets all criteria     Does not meet all criteria - Complete Action Plan with Director / designee

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Validator Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**COMPETENCY PERFORMANCE ACTION PLAN**—Use additional action plan sheets as necessary

Indicate steps employee must take in order to meet competency criteria below:

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Employee Comments: \_\_\_\_\_

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Action plan completed:    Validator Signature: \_\_\_\_\_    Date: \_\_\_\_\_