STANDARD OPERATING PROCEDURE

Nursing Shift Handover SOP

Document no.	SOP-HLC-006
Revision	1.0
Owner	Nurse Manager
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Review cycle	Every 12 months

1. Purpose

To transfer accurate, complete information about every patient between outgoing and incoming nurses so that care continues safely without delay or repeated errors.

2. Scope

Applies to nurse-to-nurse handover at shift change on inpatient units. Handover to another department, such as transfer to a different unit, is covered by a separate SOP.

Definitions

SBAR	A structured communication format covering Situation, Background, Assessment and Recommendation, used to organize a handover report.
Bedside handover	A shift report conducted at the patient's bedside so the incoming nurse can see the patient and verify key information directly.
Open task	A pending action, such as a scheduled medication, pending lab result or care task, that has not been completed by the end of the outgoing shift.

3. Responsibilities

Outgoing Nurse	Prepares an accurate report, identifies open tasks and risks, and hands off care at the bedside.
Incoming Nurse	Reviews the report, asks clarifying questions, and confirms understanding before accepting responsibility for the patient.
Charge Nurse	Oversees the handover process, reassigns patients as needed and resolves any unclear or disputed handoffs.

RACI matrix

Activity	Outgoing Nurse	Incoming Nurse	Charge Nurse
Prepare the shift report	R/A	I	I
Conduct bedside handover	R	R	A
Identify and hand off open tasks and risks	R/A	C	I
Resolve unclear or disputed handoffs	C	C	R/A

R = Responsible, A = Accountable, C = Consulted, I = Informed

4. Materials and PPE

Materials, tools and systems

- EHR with current patient chart and MAR
- SBAR handover worksheet or template
- Patient assignment sheet
- Whiteboard or handover tracking board

5. Procedure

Step	Task	Owner	Done
5.1	**Prepare the patient assignment list** Print or pull up the current patient assignment list at least 15 minutes before shift change, and note any changes in room or acuity during the shift.	Outgoing Nurse	☐
5.2	**Complete late documentation** Finish charting vital signs, medication administration and care tasks from your shift before starting handover so the incoming nurse sees a complete record.	Outgoing Nurse	☐
5.3	**Organize the report using SBAR** For each patient, prepare the Situation, Background, Assessment and Recommendation so the report is structured and easy to follow rather than a free-form narrative.	Outgoing Nurse	☐
5.4	**Identify open tasks and risks** List any pending medications, treatments, lab results, scheduled procedures and safety risks such as fall risk or isolation status for each patient. **Checkpoint:** Every open task and safety risk is written down, not just mentioned verbally.	Outgoing Nurse	☐
5.5	**Meet at the assigned time and location** Meet the incoming nurse at the designated handover location on time, minimizing interruptions from phones or other staff during the report.	Incoming Nurse	☐
5.6	**Deliver the SBAR report** Walk through each patient's Situation, Background, Assessment and Recommendation, highlighting anything that changed significantly during the shift.	Outgoing Nurse	☐
5.7	**Conduct bedside verification** Visit each patient together where practical, introduce the incoming nurse, and visually confirm lines, drains, dressings and equipment match what was reported. **Checkpoint:** High-acuity and high-risk patients are visually verified at the bedside before the outgoing nurse leaves the unit.	Incoming Nurse	☐
5.8	**Ask clarifying questions** Ask about anything unclear in the report, including the plan for open tasks, before agreeing to accept responsibility for the patient.	Incoming Nurse	☐

Step	Task	Owner	Done
5.9	**Confirm high-alert and critical information** Confirm allergy status, code status, isolation precautions and any high-alert medications due during the incoming shift. **Warning:** Do not accept handover of a patient with an unclear code status or allergy status. Confirm it before the outgoing nurse leaves.	Incoming Nurse	☐
5.10	**Transfer open tasks formally** Hand off open tasks explicitly, confirming who is responsible for each one, rather than assuming they will be picked up automatically.	Outgoing Nurse	☐
5.11	**Update the assignment board** Update the whiteboard or tracking board with the new nurse assignment and any change in patient status.	Incoming Nurse	☐
5.12	**Escalate unresolved handover issues** If the outgoing and incoming nurse cannot resolve a question about the plan of care or an open task, involve the charge nurse before the outgoing nurse leaves the unit.	Charge Nurse	☐

6. Quality checks

- Every patient handover includes a documented SBAR report.
- High-acuity patients receive bedside verification, not report-only handover.
- Open tasks are documented and formally transferred, not left to memory.
- Handover is completed within the unit's target time window.

7. Records

- SBAR handover worksheet or EHR handover note
- Patient assignment and tracking board
- Open task and risk list
- Escalation notes for unresolved handoffs

8. KPIs

- Average handover duration per patient
- Percentage of high-acuity patients with bedside verification
- Number of open tasks missed after handover
- Handover-related incident reports

9. Common mistakes

- Rushing through the report without covering open tasks or risks.
- Skipping bedside verification for a patient who looks stable.
- Leaving late documentation for the incoming nurse to sort out.
- Accepting a patient handover without confirming code status.

10. Revision history

Revision	Date	Description	Reviewed by
1.0	September 15, 2026	Initial release	Ilia Pirozhenko

Approval

Prepared by	Approved by	Date

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