| | | | | |
|---|---|---|---|---|
| Section: | Division of Nursing | ********** | Index: | 6080.001b/6090.001b |
| | | **PROTOCOL** | Page: | 1 of 2 |
| Approval: | _____ | ********** | Issue Date: | December 14, 1989 |
| | | | Reviewed Date: | January 31, 2005 |
| | _____ | | | |

HACKETTSTOWN COMMUNITY HOSPITAL

Originator: J. McChensey, RN
Reviewed by: N. Peer, RN

**3-North/4-South**
(Scope)

**TITLE: CHANGE OF SHIFT REPORT PROTOCOL**

PURPOSE: To provide shift to shift patient care planning data to nursing personnel.

LEVEL: Dependent _____ Independent ____X_____ Interdependent _____

CONTENT:

1. R.N. or LPN will give the change of shift report to oncoming staff.

2. Staff nurses will tape report during the following times:

| | |
|---|---|
| Day Shift: | 2:00 PM-3:00 PM |
| Evening Shift: | 10:00 PM-10:30 PM |
| Night Shift: | 5:00 AM-5:30 AM |

3. Reports may be taped or verbal.

4. Report will begin promptly. Late comers will be responsible to meet with their Unit Coordinator/ Resource Nurse after report to receive report. If the oncoming Resource Nurse is late, the report will be given to the second R.N.

END-OF-SHIFT REPORT CHECKLIST:

5. All patient reports must include the following data:

   a. Patient's name, age, room number
      1. Doctor(s)
      2. Hospital day, post admission or postoperative
      3. Chief complaint, diagnosis, surgical procedure, or reason for admission
      4. Changes in any of the above

   b. Nursing care needed within next 2 hours

   c. Changes in patient's condition or treatments within past 24 hours

   d. Nursing care to be given within next 24 hours

   e. Additional information, as indicated concerning:
      1. Medications
      2. Treatments
      3. Diagnostic tests
      4. Dressings and drainage
      5. Learning needs and progress toward meeting them. Plans for discharge and continuity of care
      7. Need for referral
      8. Interaction with members of health team

6. Report on any patient should not exceed 60 seconds. A patient requiring complex care, such as extensive dressing changes, may require walking rounds rather than a lengthy verbal summation.

SAMPLE: Mrs. Brooks, Room 604, age 82, admitted July 22, Dr. Baker, primary nurse Ann Donahue.

**Diagnosis**: rule out myocardial infarction (MI); congestive heart failure (CHF).

Patient came into emergency department (ED) with sudden onset of substernal chest pain, radiating to left arm. This was associated with shortness of breath, nausea, vomiting, and diaphoresis. She received intravenous (I.V.) morphine and furosemide (fursemide, Lasix) in ED, which relieved chest pain.

**Past medical history**: includes CHF, hypertension, arteriosclerotic vascular disease, angina, MI x 2 (1969, 1972)., adult onset diabetes mellitus (AODM).

**MI**: Patient had MI. Has been without chest pain since admission. Monitor discontinued. Walking in hall twice a day without assistance.

**CHF**: Had one episode of shortness of breath today, with respiratory rate up to 32. Weight was up 2 pounds; had rales a third of the way up lungs. Given 100 mg I.V. Lasix with good diuresis and shortness of breath resolved. Lasix increased to 200 mg a day. Potassium was 3.2; she was given 40 mEq of potassium chloride, P.O., at 10 a.m. and is to get another 40 mEq at 6 p.m.

**Hypertension**: Blood pressure up this admission. Range is 140 to 170 systolic over 80 to 100 diastolic. Was started on methyldopa (Aldomet) and hydrochlorothiazide. Pulse 80 to 90.

Blood glucose has been up last few days so insulin has been adjusted. Fasting blood glucose today was 298. Gave herself insulin today without difficulty.

**Discharge plans:** Will go home when stabilized. Lives alone; home-care referral has been written. Needs medication checks and reinforcement on insulin instructions.