Connecticut Valley Hospital Nursing Policy and Procedure	**SECTION B: THE NURSING PROCESS** **CHAPTER 7: NURSING PLAN OF CARE PROCESSES** **Policy and Procedure: 7.6 Nursing Report and Change of Shift Procedures**
Authorization: Nursing Executive Committee	Date Effective: May 1, 2018 Scope: Registered Nurses

Standard of Practice:

The off-going Registered Nurse will provide a pertinent report on each patient's condition, highlighting risk concerns and safety interventions as required, in addition to unit milieu issues/events to all on-coming Nursing staff.

The Registered Nurse will ensure that all patients are accounted for at change of shift and identified staff are assigned to perform environmental safety rounds.

Standard of Care:

The patient can expect that the Registered Nurse will communicate all pertinent patient information related to his/her treatment and care needs as appropriate to Nursing, Medical, and Clinical staff.

The patient can expect that change of shift is conducted in a manner that accounts for safety, security, and cleanliness.

Policy:

The Registered Nurse is responsible for ensuring that all assigned shift staff receive a comprehensive report concerning each patient's condition and Plan of Care. This is to include evaluation of risk for suicidal/self-injurious behavior. All pertinent information including Behavioral Treatment Interventions including Behavioral Plans and/or Guidelines and associated MD/APRN orders is documented and communicated to the on-coming Registered Nurse and assigned Nursing staff. This is to assure an informed, collaborative, respectful and safe treatment approach to each patient.

All patients are accounted for at the beginning of each shift by staff of both shifts. Staff from both shifts tour the unit together to ensure patient safety, security and unit cleanliness.

Staff are not permitted to leave the unit until the Registered Nurse authorizes him/her to leave. This includes during the shift, break times and at the end of shift.

Procedure:

A. Patient Count

A staff member is designated from each shift to ensure all patients are accounted for. Both employees will sign the census sheet.

B. Unit Inspection

A staff member designated from each shift will inspect all areas of the unit for safety, security and cleanliness. A sharps count shall occur per policy (see NP&P 24.12). Any areas found unacceptable should be rectified by the off-going shift. Any unresolved issues will be reported to the Unit Director and on evenings, nights and weekends to the Nursing Supervisor for immediate action.

C. Verbal Change of Shift Report

1. The off-going Registered Nurse provides a verbal report to the oncoming RN and all available members of the on-coming nursing shift staff in an area which minimizes interruption, and ensures patient confidentiality. Off-going shift staff provide unit coverage during the report so as to ensure patient supervision. Shift Report, Behavioral Guidelines and Associated MD/APRN Orders **must** be reviewed with each staff member on duty before providing care. These elements are essential to the care of our patients.

2. The off-going Registered Nurse provides a complete and comprehensive verbal report addressing the status of each patient. This report is generated from the patient care assignments of staff on each shift. In particular, the Charge Nurse references all patients nursing plans of care which is derived from the MTP or any F-TPR). Report focuses on the following areas for each patient when appropriate: Behavioral changes, mental status changes (risk assessments including self- harm and/or dangerousness to others), use of special treatment procedures, i.e. seclusion and restraint, medical problems, and/or conditions involving recent or anticipated changes, observation and privilege level changes, **participation in Team Engagement activities,** medication changes including the use of PRNs, critical test results and other significant laboratory tests, vital sign alterations, and the patients' use of medical equipment (e.g. chair or bed alarms, oxygen, suction, pulse oximeter), trauma experienced while in the hospital, legal issues, outside appointments, incident reports, discharge planning activities and any other nursing care issues addressed on the nursing plan of care are reported. The report will also include the general mood of the unit and factors which may have influenced the milieu.

3. The off-going Registered Nurse regards this hand off communication as interactive thereby allowing the opportunity for questioning between the giver and receiver of patient information. All on-coming nursing staff are required to receive handoff report and verify receipt of information by signing the 24 hour report form (7.6a). Signatures affirm awareness & review of Behavioral Guidelines and Associated MD/APRN Orders. The Registered Nurse providing hand off report confirms that ALL Nursing Staff on duty have signed this form. This signature is documented on the 24 Hour Report form (7.6a). The off-going Registered Nurse will document that the report was given by also signing the 24 Hour Report.

4. Information on new admissions/transfers which includes pertinent data such as

physician, the patient's age, reason for admission or transfer, current medications, significant medical and psychiatric history and treatment are communicated.

5. The on-coming Registered Nurse, as the receiver of the hand off information is provided with the opportunity to review relevant patient historical data, which may include previous care, treatment, and services**, and seek clarification as requested.**
6. The off-going Registered Nurse advises the on-coming staff of any changes in policies and procedures**, and clarify any outstanding questions**.

7. Staff arriving after change of shift report are required to report to the Charge Nurse for the shift report. They will sign the 24 hour report to verify that it was received.

8. Each employee is accountable and responsible for knowing the information given at shift report.

D. Written Change of Shift Report

1. The night shift initiates a unit based twenty-four hour report and dates the report and enters all patient names in alphabetical order.

2. The Registered Nurse on each shift maintains a written unit based twenty-four hour report.

3. Documented information includes but is not limited to:
   a. Census
   b. Special Observations
   c. Leaves
   d. Admissions, Discharges, and Transfers (ADT)
   e. Significant change of condition or risk described on FTPR
   f. **Patient participation in Team Engagement activities**

4. Pertinent individual patient behavioral and/or medical status information changes are documented on every shift.
   a. Shift
   b. Name of patient (last name, first initial)
   c. Level**/TE (in addition to level; include TE to signify Team Engagement)**
   d. Observation Status
   e. Patients at risk of harm to self or others (inclusive of suicidal/homicidal ideation gestures or attempts).
   f. Behavioral Treatment Interventions including Behavioral Plans and/or Guidelines and associated MD/APRN orders
   g. Any episodes of restraint or seclusion
   h. Special medical treatments and medical equipment used
   i. Medication changes
   j. Medical status changes
   j. Incidents (i.e., falls, unexplained injuries, AWOL)

k. Experience of/or exposure to trauma
l. Any suspected substance use
m. Inappropriate sexual activity
n. Any illegal activities
o. Possession of non-permissible items that are considered dangerous for the patient or the milieu
p. Significant increase in symptoms
q. Persistent non- adherence to prescribed treatments
r. Level holds

5. Patient privilege levels will be indicated on the 24-Hour Report Form.

6. Patients who require engagement activities will be indicated with "TE" in level column with actual level.

7. Report should also indicate who is due for Annual Assessment and CASIG, including a notation on completion.

8. The unit based 24-Hour Report form is completed at the end of each shift to provide the Nurse Supervisor with a concise and accurate report regarding unit status including census, patient movement, special observation and significant patient and unit events. Each unit submits a 24 Hour Report form to the Supervisor's office.

9. The unit based 24-Hour Report form is used by the unit along with patients nursing plans of care itself for both cross shift communication and general information. Information is also used by the Nurse Supervisors for cross-shift communication.

10. The unit based 24-Hour Report form is processed according to Division practice:
a) Addictions: Reviewed by Nursing Supervisor.
b) General Psychiatry: Reviewed at the Daily Quality, Risk and Clinical Review Meeting.