Nursing Reports; Unit Shifts/24 Hr. Report; NAO Shift Report

Purpose

To provide guidelines for nursing staff to communicate information at the change of shift about each patient, unit activities, and special incidences. To give nursing administration special information necessary to plan for patient care and to meet requirements to regulatory agencies.

Scope

This policy applies to all patient units.

Policy

A. Shift reports will be given on each unit each time shift change occurs by using the "Shift and Twenty-Four-Hour Report."

B. Reports will be given in a designated place that will allow for exchange of information without constant interruption and the breach of patient confidentiality.

C. The charge nurse or designee of the departing shift will provide a report to the oncoming shift, utilizing the information in the Shift and Central Nursing Office Report. The 24-hour report is presented daily to the treatment team by shift charge nurse. The unit psychiatrist or covering physician will sign the report indicating that they have received it.

D. The charge nurse of the oncoming shift will ensure that each staff receives report when they report for duty.

E. During report, members of the departing shift will remain with the patients until the report is over.

F. During each shift, the 24-hr. report will individually address every patient currently assigned to the unit including information such as: current physical/mental status, significant changes in progress, changes in treatment and/or medication, special nursing needs and other issues as relevant.

G. The assigned staff will record in the shift report all pertinent data as listed in procedure on every patient to whom he/she is assigned on the patient assignment sheet.

H. The Shift and CNO Report form must be maintained on file, on each ward in chronological order for 5 years.

I. The Unit Manager is responsible for assuring that this policy and procedure is carried out as outlined.

Procedure

A. Unit Shift Report: At the beginning of day shift, upon completion of the patient assignment sheet, the day Shift Charge Nurse/Designee will validate correctness of form initiated by the prior night shift staff.

1. Complete lines for unit census, date, and page numbers.
2. Validate and list patient names on the lines provided, one patient name to one space, listing 1:1s, CCOs, COs first, indicating precaution and level of observation below the name.

B. Each shift completes the staffing profile by listing number of staff by classification in the square on page one.

C. During each shift, complete in ink all information as described below which pertains to the patient(s) assigned or with whom interaction occurred (all assigned staff).

1. Charge Nurse or Designee will note number of incidents (admissions, transfers, discharges, etc.) at the top left-hand side of the shift report. Include details in the space provided after the patient's name as described below:
   a. **Special Incidents:** State time and type of incident, injury, any patient, or staff involvement.

b. **Admissions and Re-admissions:** Include time arrived on unit, diagnosis, reason for the admission, vital signs, mental/ emotional status i.e., "confused", hallucinating", "agitated", medical problems, legal status, observation level and precautions.

c. **Transfers Off Unit:** Include time patient left, with whom, destination, reason for transfer.

d. **Discharges:** Include time patient left the unit, destination, with whom he/she left, and state whether medication teaching was done, and if the patient had his/her prescriptions and After-Care plan.

e. **Elopement:** Describe situation, state if family/authorities were notified, and time of elopement, return, or if still on elopement.

f. **Code Blue:** Time of occurrence, brief description of situation surrounding occurrence (i.e., "patient found on floor in respiratory arrest.") disposition of patient (i.e., "to hospital.")

g. **Code Green:** Time of occurrence, brief description of situation (i.e., "patient began beating another patient"), disposition of problem (i.e., patient placed in seclusion/restraints.")

h. **Seclusions:** Time in and time out of seclusion, brief description of patient's behavior and mental/emotional status during the shift. Must state if patient remains in seclusion and why.

i. **Restraints:** Time in and time out of restraints, brief description of patient's behavior that led to restraints, description mental/emotional status during the shift. Must state if patient remains in restraints and why.

j. **Accidents:** Complete an accurate description of the situation surrounding the accident, be objective, i.e., "Patient found on the floor, says he fell", take the vital signs of patient. Describe the actions taken by staff in regard to the incident, i.e., "Doctor notified and evaluated the patient, ordered an x-ray, which revealed a broken bone."

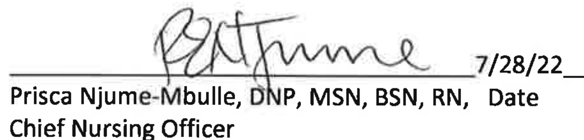
2. Report group activities held during each shift at the top of the shift report.

3. Include pertinent patient information for each shift in the spaces provided as follows:
   a. Mental/Emotional status and changes. Use psychiatric terms but describe the behavior. If there are no changes, state (i.e., "still hallucinating", or "no changes in content of delusions or hallucinations", still undresses in the hallway.")
   b. New physical problems, status and care given for ongoing medical problems. Include vital signs ordered for the shift.
   c. If appropriate, shift reports should include the following:
      1. Changes in medications schedules or PRN's given with rational and effectiveness.
      2. Changes in privilege level with rationale.
      3. Changes in vital signs.

4. Changes in precautions and/or attempts made.
5. Clinics attended and results, if available.
6. Stat abnormal/critical blood and lab results if available.
7. Sleeping and eating problems with nursing interventions.
8. Behavior problems (i.e., "agitation", withdrawn", and "social interaction" along with nursing interventions and patients' responses.
9. ADL problems and related interventions.
10. Incidents (i.e., "falls, patient to patient & patient to staff altercations" – physical or verbal.)
11. Family visits, visitors, or problems during visitation, and resolution of problems.
12. Special problems with specific patients that need to be communicated to another shift (i.e., "Mr. B. appears to be checking his medications, please monitor him when giving his medication", or "Mrs. C. has very poor hygiene, please check that she bathes this evening.")
13. At the end of each shift, a) circle the term that describes the "milieu" for the shift, b) assure that groups held are listed, c) note that "special incidents" are described accurately (these are to be included as part of the shift report to the oncoming shift), d) sign name and classification on appropriate line at the top of shift report column (charge nurse or designee.)
14. NAO Shift Report:
    1. Prior to the end of each shift the Charge Nurse or designee will complete that shift's section of the NAO shift report, sections for census (admissions, discharges, LOA, transfers), and patient status levels (identifying the number of 1:1 and CCO patients). All staff that worked on the unit for that shift is to be listed in the "staff on duty" area. The report content should include special incidents as listed on page 1 & 2 as well as pertinent patient information as listed on page 2 of this policy.
    2. Each shift completed report is to be signed and faxed to the NAO, one hour before the end of the shift.
15. Daily Clinical Report
    1. The NAO supervisor extracts the pertinent information from the NAO Shift Report from each unit to complete the shifts portion of the daily clinical report.
    2. When there is unusual incident/accident that requires family notification, the shift's charge nurse will record the status of the notification.

16. The Daily Clinic Report is presented to the Chief Nursing Officer and Assistant Director of Nursing daily. A copy of the report is submitted to the Hospital Chief Executive Officer, Chief Medical Officer, Chief Compliance Officer, Pharmacy, and Infection Prevention & Control.
17. Store the Daily Clinical Report and NAO Shift Report chronologically in a designated file for 5 years.
18. At the end of 5 years, the reports are shredded.

Approved by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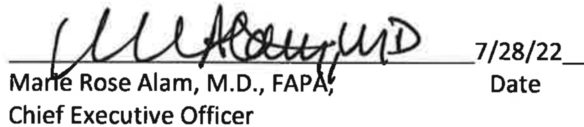
Prisca Njume-Mbulle, DNP, MSN, BSN, RN, Date
Chief Nursing Officer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Marie Rose Alam, M.D., FAPA, Date
Chief Executive Officer

EO

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