Penn Medicine
Lancaster General Health

STANDARD WORK

Process Name: _____Patient Centered Nurse Report_____

Owner: _____Tracy Miller_____
Revision # 3 **Last updated: 10/24/19**

Expected Outcomes: Consistent hand-off shift report between nurses focusing on patient participation, quality and safety.

	Major Steps	Key Points	Scripting
1	Pre-Report **Preparation**	1) Know patient preferences regarding family and friend participation. 2) Ask patient visitor and roommate visitor to step out of room based on patient pre-known preferences. 3) Starting one hour before shift report, round on patient and address toileting, food, comfort and pain relief. 4) Update communication tool with patient preferences for the next shift.	**Scripting Options:** Outgoing RN: For the next 5 minutes, we want to talk with you about what is going on with you or what you day/night was like. Oncoming RN: I want to learn more about what is going on with you. We want to talk about any changes in the last 24 hours. Can you share with us what is most on your mind. I am sorry that you are in pain. That is such a great question, let me come back and talk it through with you when I come in with your medications/care. I am going to check on that for you and be back with an answer.
2	Patient Centered Nurse Report - Outgoing/Incoming Nurse - **Introduction**	Note: **Protected health information**: HIV status, mental health, substance abuse and/or new diagnosis not yet known to patient is **reviewed in a private area.** 1) **Set aside an e-cart to review medications and orders after speaking with the patient/family.** 2) Outgoing nurse introduces incoming nurse. 3) Position sitting with or facing the patient. 4) **Outgoing nurse** facilitates interaction during report.	
3	Patient Centered Nurse Report - Outgoing Nurse - **Story/History**	1) **Patient/family tell story of the past shift.** 2) Review admission date, reason for admission and treatment team. 3) Brief summary of significant events in the last 12 hours (oncoming nurse avoids questions that are easily accessed in EMR). 4) Review of systems. 5) **Relevant history** as it relates to **current condition.** 6) Plan for day; plan for discharge. 7) Last pain medication administered, anticoagulants and antibiotics	
4	Patient Centered Nurse Report - Outgoing/Incoming Nurse - **Assessment**	Both nurses complete a focused assessment together for patient specific needs and necessity: a) Neuro checks, b) Drains - wounds, central lines, Foley, c) Wound VACs d) Line tracing - IV, O2, e) Pressure injuries, f) Restraints, g) Neurovascular checks	
5	Patient Centered Nurse Report - Outgoing Nurse -**Plan**	Outgoing nurse reviews POC and overall treatment goals; encourages patient to set goal; communication tool updated with goal; discuss any pending tests or procedures. Document preferences and goals to reflect individualization and mutuality.	
6	Patient Centered Nurse Report - Outgoing/Incoming Nurse - **Error Prevention**	Perform safety checks: 1) **Verify ID, DNR**, limb alert and Blood Bank bands. 2) **Verify Elopement** status and document as needed. 3) Bed/chair alarm on. 4) Call bell and necessary items within reach. 5) IV infusions double-checked and co-signed as needed.	
7	Post-Report - Incoming Nurse - **Dialogue**	Ask patient/family if they have any questions or concerns; review expectations and time frame for when nurse will return for hourly rounds, medications and care. **Remember: Review medications and orders after speaking with the patient/family.**	