

## Abstract:

Shift report is an integral piece of nursing. It is an "occupational ritual" used in many settings to communicate information from shift to shift. Bedside handoff reports were developed to improve communication among caregivers and patients and to meet National Patient Safety Goals in 2006 to improve the "effectiveness of communication among caregivers". Many institutions developed standardized approached to handoffs. In 2007 at Advocate Christ Medical Center we developed our 5 P Handoff tool (5P tool). This tool included the **P**atient name and diagnosis, **P**recautions/History, Purpose/Desired Outcomes, Plan of Care and Problems/Discharge Barriers. Wound care/Pressure Ulcer was a section of its own. The 5 P tool was tweaked to meet the needs of our rehabilitation patients. Highlights included fall risk, transfers, bowel and bladder program, patient teaching and discharge planning. "My Daily Plan" is being introduced April 1, 2013. The purpose of the plan is to improve patient safety and the quality of bedside shift report by including the patient in the day's plan and giving them a written plan. The patient's daily plan is discussed during bedside shift report and updated throughout the day. A new plan is generated every day. Included in the daily plan is pending tests, new medications, therapy schedules, what I did today, what worries me and barriers to discharge. Our goal with bedside shift report and the patient's daily plan is to see an improvement in patient safety, patient satisfaction and a decrease in report time through enhanced communication.

## My Daily Plan

New medication	
	What worries me:
	• Today
Common side effects	
Physician	
	About My Medications
	About My Discharge
Thornaida DT OT ST Dessistant	
	Barriers to Discharge
How I did today:	bainers to Discharge
I would like information about	
I would like information about:	Family requests/needs
I would like to meet with (places initial)	
Dietician Social Services	
Pain Service      Pastoral Care      Other	
	Physician

## **5 P Hand off Tool**

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## **Current White Board** in Patient Room

ound Care (See other side

ROOM	PHONE NUMBER TO ROOM	
	798-684	
Name	Discharge Date	
Rehab Doctor:		
Social Worker:	-	
а. 19		
RN:	Phone Extension	
PCA:		
Level of Assistance:		54) 
	-	
	54-	
		12. 12.
Exceptional Care =		

M is for new meds as a reminder to the nurse to Review with the patient the new med, side effects, Indication.

## "My Daily Plan" Irene Tranowski, MSN, CRRN 39<sup>th</sup> Annual ARN Educational Conference Charlotte, NC

# **Daily Therapy Schedule**

Name **Daily Schedule** 

7:30 - 8:15	
8:15 - 9:00	
9:00 - 9:45	
9:45 - 10:30	
10:30 - 11:15	
11:15 - 12:00	
12:00 - 1:00	LUNCH
1:00 - 1:45	
1:45 - 2:30	
2:30 - 3:15	
3:15 - 4:00	
4:00 - 4:30	

Room

## **Bedside Shift Report Competency Checklist**

	BED-TIDE SHITT REPORT COMPETENCY (GEECK) ST	
Validation	#: 1 1 2 1 3 Date: Name: Role:	
		Unit:
Check if Observed	ESSENTIÁL SKILLS	NOTES OF ST AREAS IMPROVE
INTRODUC	CTIONS	
	Knock on door prior to entering ask permission	
	Wash Hands / Foam in	
	Manage up – outgoing nurse will introduce incoming nurse	
EXPLAIN B	EDSIDE SHIFT REPORT	
	Assess for primary language and hearing deficits	
	Explain the purpose of bedside shift report (upon admission & with each shift report)	
	Use key words "safety", "always", and "very good"	
	If visitors are at bedside, obtain patient's permission to have them present during	
	information exchange to maintain HIPPA regulations. Please do the same, if roommate is	
	present.	
SAFETY &	ASSESSMENT	a la sala a fa
	Both nurses check name & allergy bands prior to any care, using key words "for your safety".	
	(Fall Precautions, LET, etc.)	
	Conduct Verbal SBAR report with patient & family:	
	<ul> <li>Situation: What is going on with the patient?</li> <li>Background: What is the pertinent patient bistory?</li> </ul>	
	<ul> <li>Background: What is the pertinent patient history?</li> <li>Assessment: What is the patient's problem now?</li> </ul>	
	Recommendation: What is the Plan of Care?	
	Review tasks that need to be done:	
	Labs, tests, and OR checklists	
	<ul> <li>Patient's current pain rating &amp; update white board</li> </ul>	
	<ul> <li>Medication including "M" in the box</li> </ul>	P
	Mobility	
	Visually inspect all wounds, incisions, drains, IV sites, IV tubing, catheters, IV pumps, guardrail and bed alarms	
	Do a visual sweep of the room for any physical concerns. Move items within reach (table,	
wirepass of	call bell/TV remote, phone, water & garbage can)	
INFORM 8	ENGAGE WITH PATIENT & FAMILY UTILIZING "MY DAILY PLAN" (MDP)	
	Update names, date, nursing plan, tests & treatments on white board. Use layman's terms.	
	Use key words "keep you informed", "plan of care", "tests" & treatments, etc.	
	Ask "What questions can I answer? What is most important to you today?"	
	Perform teach back	
CLOSING -	THANK YOU	
	Thank you for allowing us to provide your care. Is there anything that I can do for you?	
	Can I close your door of pull your curtain for your privacy?	
	Foam Out (if patient has C-Diff, then use soap & water)	
Woul     Evaluator	d be a good mentor to others Evaluator:	

+ Advocate Christ Medical Center Hope Children's Hospital



Inspiring medicine. Changing lives.

## **Implications for Practice:**

The "My Daily Plan" was introduced in April of 2013 as part of bedside shift report. The purpose of the plan was to keep the patient informed of daily activities/tests and procedures. The "My Daily Plan" sheet would be given to the patient every 24 hours during bedside shift report and updated throughout the day as tests were scheduled. Diet, new medications, labs, therapy schedules, and questions the patients may have and discharge barriers were to be addressed. On the rehabilitation unit we has been using the "White Board" and daily therapy schedule as a means of keeping our patients informed of their daily schedule. The "White Board" included discharge date, physiatrist name, caregivers names, transfer assistance needed, the patient's goals for the day and description of "Exceptional Care". The average length of stay on the inpatient rehabilitation unit is 14 days. This meant that the patient had at least 14 different "My Daily Plan" papers. We found this to be confusing and a lot of paper used. In order to not confuse the patient with many forms we started to use one sheet and update daily. Again after a few days the papers got lost or messy. Although the "My Daily Plan" was appropriate for the medical patients with a shorted length of stay and more tests being ordered, on the rehab unit it proved to be unnecessary paper work due to the processes already in place. We are currently looking at modifying our white boards to a "My Daily Plan" format that can be changed with a dry erase marker as needed and provide a visual of their daily activities in addition to their therapy schedule. Bedside shift remains in effect to include the patient in their care planning, keeping them informed of any testing and answer any concerns. The daily plan of the patient is included in the bedside shift report. By eliminating the paper "My Daily Plan" we have decreased the paper work time of the nurses to be able to focus on the questions and needs of our patients. My Daily Plan will be replaced with the erasable daily Plan of Care "White Board".

### White Board Plan of Care

	My Daily Plan		
Keeping Me Informed			
Room	RN		
Phone 708-684	РСА		
Name	Social Worker		
	Rehab Doctor		
Transfer assist			
My Goals are			
Exceptional Care=			
Tooto To dou			
New Meds			
Discharge Questions			
Discharge Date			

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