"My Daily Plan"

Irene Tranowski, MSN, CRRN

39th Annual ARN Educational Conference

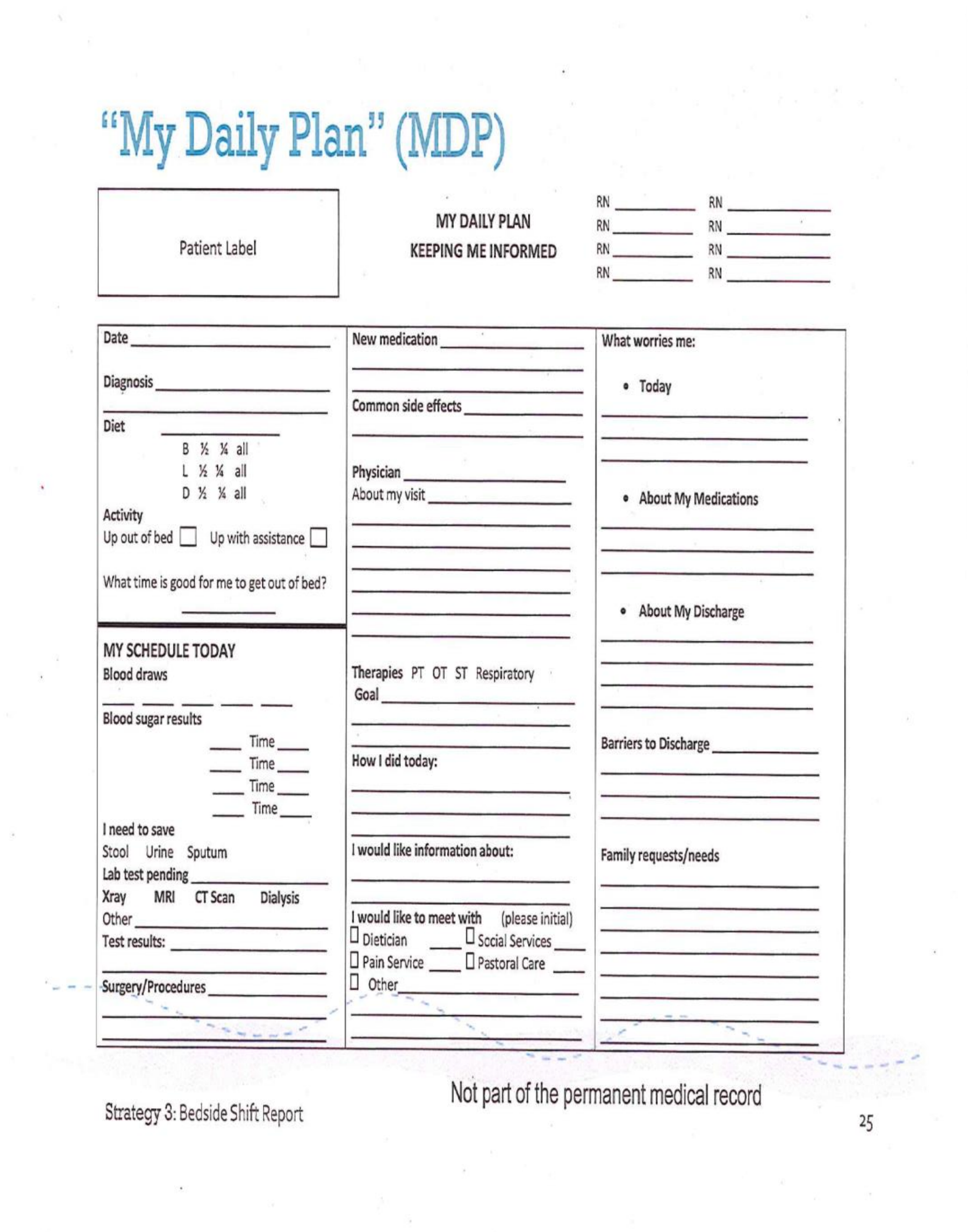
Charlotte, NC

Advocate
Christ Medical Center
Hope Children's Hospital
Inspiring medicine. Changing lives.

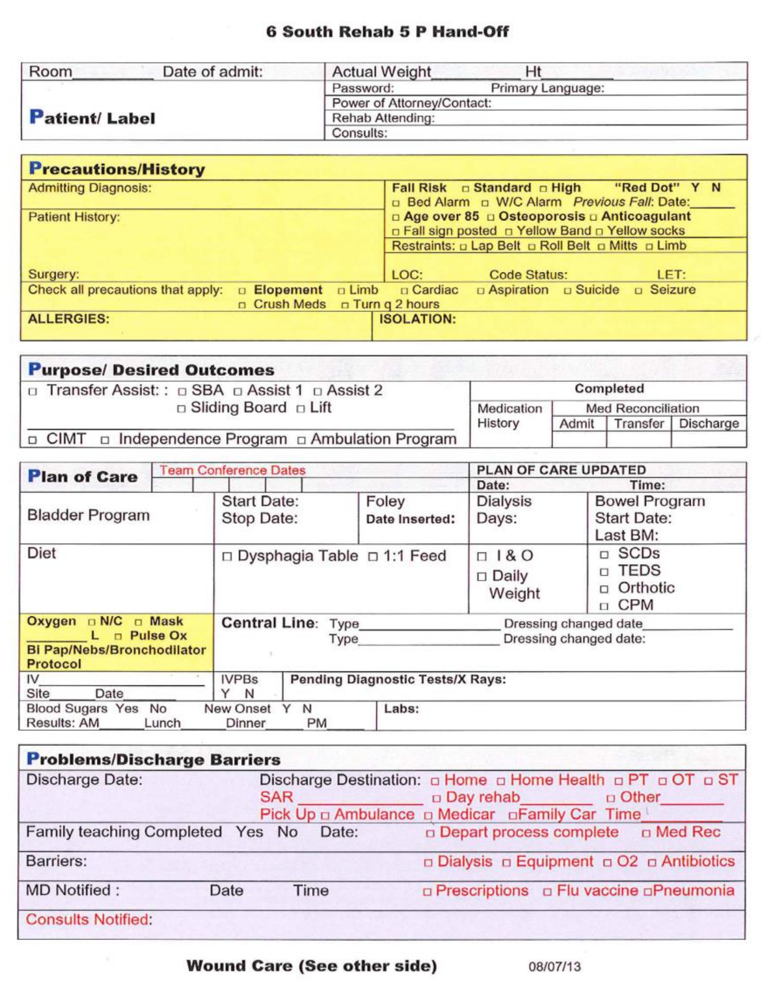
Abstract:

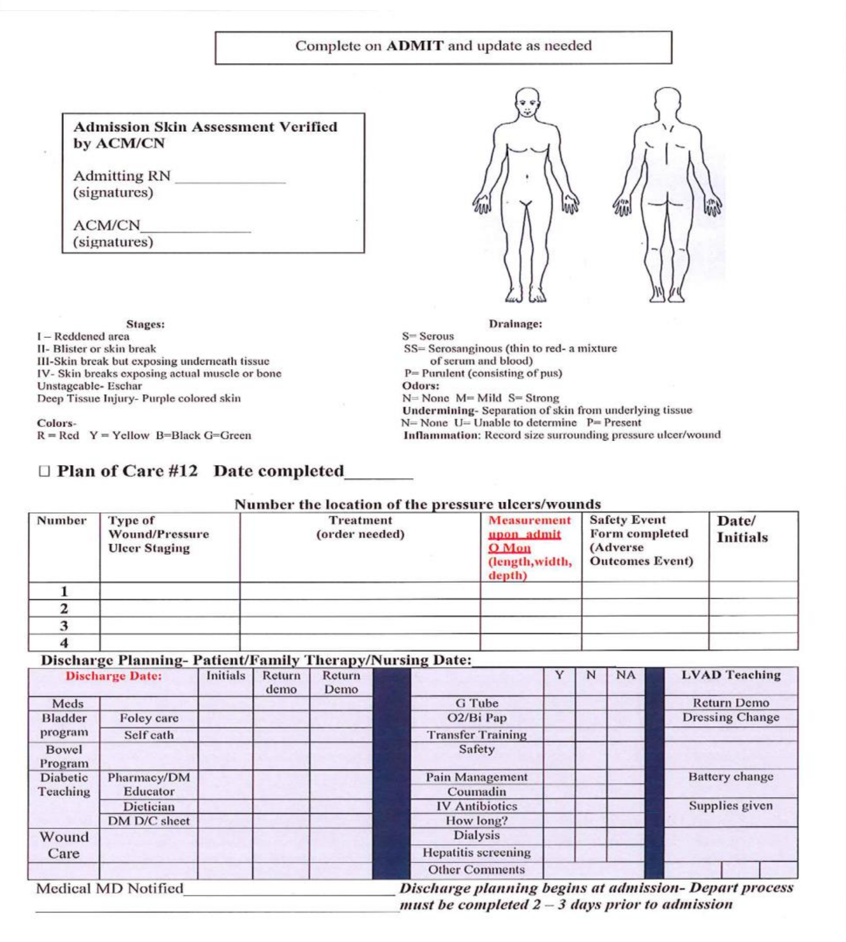
Shift report is an integral piece of nursing. It is an "occupational ritual" used in many settings to communicate information from shift to shift. Bedside handoff reports were developed to improve communication among caregivers and patients and to meet National Patient Safety Goals in 2006 to improve 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, **P**urpose/Desired Outcomes, **P**lan of Care and **P**roblems/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



5 P Hand off Tool





Current White Board in Patient Room

ROOM

PHONE NUMBER TO ROOM

798-684-_____________

M

Name____________________ Discharge Date____________________

Rehab Doctor:____

Social Worker:____

RN:____________________ Phone Extension____________________

PCA:____

Level of Assistance:____

Today is:____

My Goals are:____

Exceptional Care =____

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

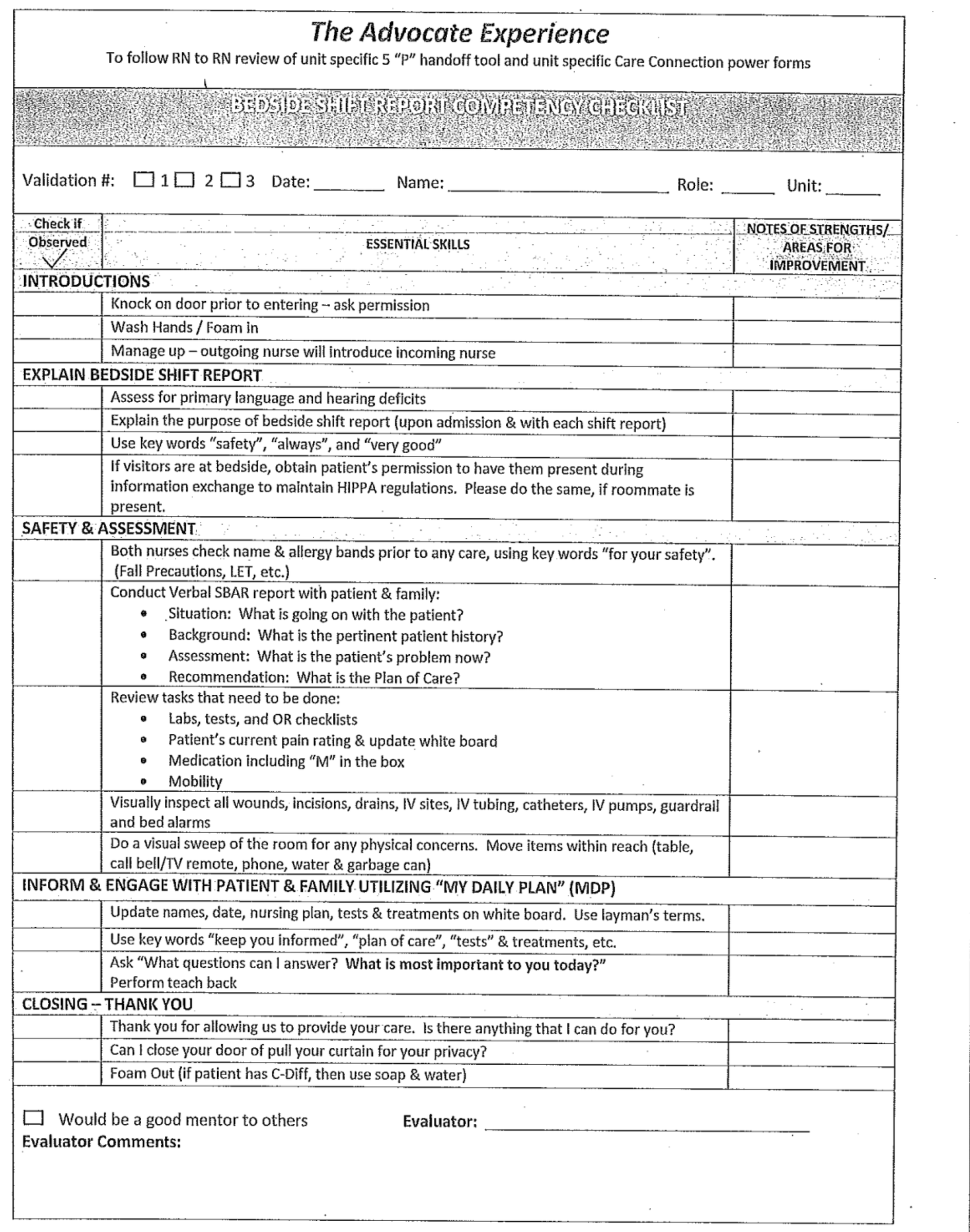
Daily Therapy Schedule

Name_________________Room____

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	

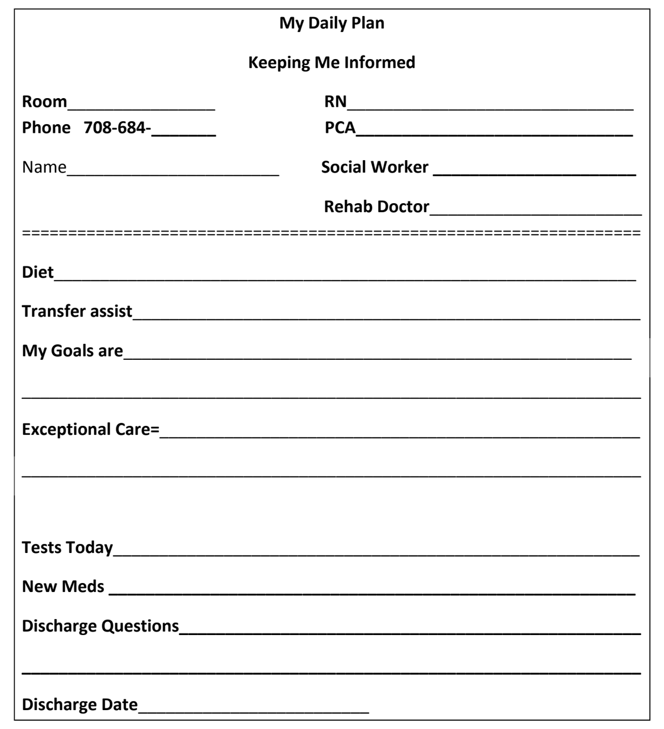
Bedside Shift Report Competency Checklist



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



References:

Benson, Ember BN, RN, Rippin-Sisler, Catherine, MN,RN, Jabusch, Kimberly MN, RN, Keast, Shelly MN,RN. (2006). Improving Nursing Shift-to-Shift Report. *Journal of Nursing Care Quality.* Vol.22, No. 1 pp. 80 – 84.

Evans, Deby, Grunawalt, Julie, McClish, Donna, Wood, Winnie, Friese, Christopher R.(2012). Bedside Shift-to Shift Nursing Report : Implementation and Outcomes. *MedSurg Nursing*. Vol 21. No 5.

Hays, Mary M., Weinert, Clarann. (2006). A Dramaturgical Analysis of Shift Report Patterns With Cost Implications: A Case Study. *Nursing Economics.* Vol. 24. No.5