CHANGE OF SHIFT REPORT

DO REPORT:

1. Room number
2. Name
3. Diagnosis or surgery
4. IV with credit
5. Condition and location of dressings, wounds, and any tubes
6. Voiding on post-op patients
7. Any tests, treatments, or permits which need to be done
8. Abnormal conditions (VS, BP, uncontrolled pain/nausea, etc.)

DON’T

1. Read everything on the computer care plan; that is why it was entered – to ensure communication between shifts.
2. Don’t give stable VS unless that is pertinent to the patient’s condition.
3. Don’t tell stories during report.

RULES TO REMEMBER:

1. Thirty minutes is all that is allotted for report.
2. Gather IV credits for report at:
   a. 1400 on 7-3 shift
   b. 2200 on 3-11 shift
   c. 0600 on 11-7 shift
3. If a patient had a quiet day – no problems – just say so. No need to waste time on a patient that did not require time.
4. Report is designed to inform the oncoming nurse of the immediate needs of the patient. He/she is ultimately responsible for assessing and planning the care for that shift.
5. Oncoming nurses need to avoid unnecessary questions and conversations.
6. Record report or be ready to give an oral report stat after narcotics count is complete.
7. Organize your thoughts and give a brief report. Lengthy reports result in boredom and chit-chat.