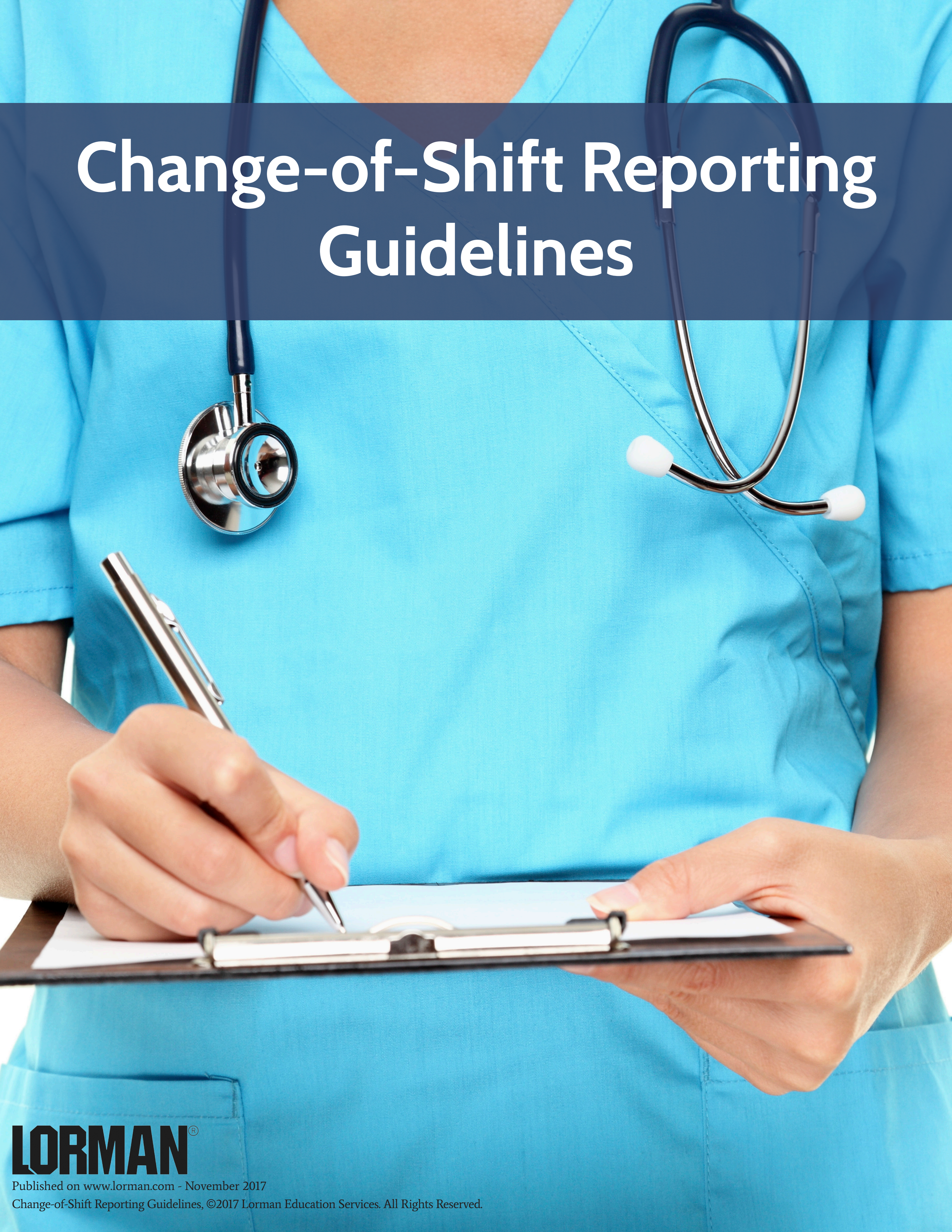
Change-of-Shift Reporting Guidelines



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To ensure patient care is consistent and sound, requirements have been developed to accommodate the need to transfer pertinent patient information between nurse staff at shift change. A change of shift report may also be called an intershift or handover report. Essentially, the report is a verbal, written, or computerized communication, or combination thereof, between two shifts of nurses. Change of shift reports are intended to convey relevant and relatable patient information between nursing staff shifts so little or no interruption in patient routine, medications, or care occurs. The primary purpose of shift change reports is to make the process of continued patient care move smoothly between nurse shift changes for the patient as well as the staff.

Accurate content of shift change reports provide nurses with pertinent information in which to arrange and prioritize patient care. Information contained in the reports help the nursing staff to make appropriate clinical decisions. Shift reports also encourage collaboration among nurses as well as the consideration of the patients' rights to be informed about their treatment in accordance with the individual's situation and relevance. The reports engage the nursing staff directly and indirectly with the patient and provide background information helpful in patient malady resolution.

Shift change reports contain information about procedures and events that occurred during the previous nurse's shift. Information contained in the report includes, but is not limited to:

• General patient care including tests and procedures,
• Administration of medications,
• Consultations and communications with other health care providers about general conditions, and
• Doctors' orders and recommendations.

It is important that the competent nursing staff is capable of quickly and accurately evaluating and documenting the patient's status. Procedures, results of diagnostic tests, administered medications, and fundamental information regarding allergies, patient mobility and fall risk, and type of resuscitation when relevant are documented. Nurses access and collect patient data to prepare end of shift reports throughout their shift. They may reference paper charts, computerized records, observation reports, and use other reporting tools available.

Nursing shift reports are also a means of education for entry-level nurses and mentors, as well as validation of nurses' practical decisions, demonstrated expertise and practicum, as well as team cohesiveness.

Regardless if the shift report is handwritten or computerized (entered online), information accuracy, patient privacy, and report completion prior to shift rotation and before the nurse physically leaves the work station is mandated by various federal (Health Information Portability and Accountability Act (HIPAA), Department of Social and Health Services (DSHS), Joint Commission on Accreditation of Health

Care Organizations (JCAHO) U.S. Office of the Inspector General (OIG)) and state guidelines. These guidelines address report requirements, format, timeliness, patient privacy, and general use.

Format and Care Goals

When used correctly and consistently, the standard shift change report format is proven to improve process efficiency and reduce errors. It provides concise information and reduces time it takes for the nurse to complete the process. A sample standard shift rotation handoff process typically includes:

• Two (2) nurses (RNs) going into the patient's room,
• The patient being introduced to the oncoming shift nurse,
• Both nurses reviewing the electronic medical record,
• Depending on circumstances and patient status, the patient may also view the record while the nurses discuss his or her general condition, assessment, medication, medical issues and plans, discharge, etc.,
• Both nurses participating in a visual and verbal patient safety check that includes the patient's malady or wound, IV, or other medical apparatus,
• Asking the patient if he or she has any concerns, questions, or comments about his or her treatment, care, or general needs,
• The outgoing nurse documenting the patient's name and "care goals," and
• Depending on the patient's status, the nurse asking the patient to repeat back his or her understanding of the "care goals."

The ultimate goal of nurses communicating pending patient care status and progressive care goals at the patient's bedside is to accommodate visual and verbal information exchange and awareness between the nurses and among nurses and the patient when the interchange is appropriate. This interactive communication is intended to encourage confidentiality, privacy of information, and professionalism. Good professional judgment and discretion are essential and mandated in accordance with guidelines that regulate and monitor activities to reduce medical care errors and oversights. These interchanges are also necessary to maximize the exchange of patient information while preserving patient privacy.

Errors

The Institute of Medicine has sufficiently documented research regarding the association between the safety of the patient and breakdowns or complete communication failures. In an effort to mitigate errors, government healthcare agencies, policymakers, and organizations have investigated the number and type of shift change report errors and have concluded that shift report software programs, wireless modes, and information technology are valid and valuable preventive measures that should be implemented.

Inaccurately communicated shift information has harmful to disastrous effects and ramifications. Misinterpreted, omitted, or biased information compromises patient safety. Incomplete reports have the propensity to misdirect nursing oversight. Such oversight eventually leads to a breakdown in identifying and preventing potentially critical patient problems (i.e.: a patient wandering away from the facility; suicide attempt).

According to the Joint Commission on Accreditation of Health Care Organizations (JCAHO) communication failures is a primary cause of compromised patient safety and security in the U.S. The JCAHO cites shift reports and reporting as a main cause and concern. There are always potential legal ramifications of not following established shift reporting policy and regulations.

Patient Information Privacy

HIPAA (Health Information Portability and Accountability Act established in 1996) provides regulations that adequately clarify the parameters of patient privacy. It is the first federal law to comprehensively address health privacy as it relates to healthcare organizations, clinics, hospitals, doctors, and dentists. HIPAA is quite clear regarding who is authorized and entitled to patient information and patient care involvement. All patient information, from diagnosis and treatment to personal conditions, is confidential. Any infractions that compromise patient privacy as well as safety and care are routinely reported to the hospital/facility administration and then to HIPAA.

• Privacy laws require nurses to complete their report before being legally permitted to leave the facility.
• Failure to do so may result in "revocation of the nurse's license" on grounds of "abandonment."
• The report may be conducted and completed where non-nursing staff and public cannot hear or see the report.
• Discretion is needed in instances where direct shift change interaction with the patient is included in the report.
• Some facilities do not permit family visitations during shift change reporting periods.

HIPAA compliance includes electronic transactions. It states it is illegal to disclose any kind of PHI (protected health information) including patient and payment history to anyone other than the individual's healthcare provider of insurance without the patient's permission. Not only are doctors, nurses, dentists, and healthcare facilities under HIPAA privacy regulations, but so are IT solutions providers and technical data service and records storage companies.

"According to privacy regulation, documents relating to uses and disclosures, authorization forms, business partner contracts, notices of your information practice, responses to a patient who wants to amend or correct their information, the patient's statement of disagreement, and a complaint record bust be maintained for 6 years (See 64 Fed. Reg. 59994)."

• Medical records (billing, Medicare, maternal and child health) must be retained for 6 years.
• Health records must be retained for 2 years after a patient's death.
• Original-legally produced hospital forms must retained for 5 years.

Health information privacy standards are issued on a national level by the U.S. Department of Health and Human Services (DHHS) in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The regulations offer privacy protection of protected health information. The DSHS Privacy Rule overrides general privacy rules and permits health information disclosures without individual consent. Public health authorities are permitted by law to gather information pertinent to the prevention or control of injuries and disease, or various disabilities from materials including shift change reports. The intent and purpose is specifically geared toward public health investigation and surveillance as well as mitigation and intervention.

HIPPA Compliance

HIPAA requires health records that are used within specific federal law and guidelines to maintain patient anonymity. "The standards require each person who maintains or transmits health information to maintain reasonable and appropriate administrative, technical and physical safeguards to ensure the integrity and the confidentiality of the information. You must also protect against any reasonable anticipated threats or hazards to the security of integrity of the health information, and unauthorized uses or disclosures of the information."

HIPAA has also enacted "Electronic Signature Standards." These may be nurse, doctor, patient, or administration signatures. Electronic signatures function as digital agreement to disclosure and transmission of information. Standards for HIPAA compliance in using patients' electronic signatures is in conjunction with the Secretary of Commerce. HIPAA rules state that electronic signatures for release of healthcare information are separate from other patient security and privacy rules, since a "signature is proof of intent" rather than "a security mechanism." The ESIGN Act of 2000 expounds on electronic recordkeeping and signatures, warning against signature "marks," garbled verbal/sound signatures, and weak systems of electronic recordkeeping. Forgery and misinterpretation are always legal possibilities and HIPAA attempts to mandate standard authentication rules.

HIPAA Compliance Audits inspect all practice aspects from patient examination and admission, to procedures and charts, to check-out. Staff must be knowledgeable, experienced, and trained in HIPAA guidelines and practice in accordance with regulations of HIPAA as well as other legal mandates. Government and insurance audits are not uncommon. It is advisable to comply rather than be fined and pay to adjust the organization and routines to be in compliance with the privacy guidelines. The OIG (U.S. Office of the Inspector General) identifies HIPAA Compliance elements that include but are not limited to the following:

• Conduct internal audits
• Monitor practices and procedures and documentation
• Follow the HIPAA Manual and implement HIPAA Compliance & Practice Standards.
• Designate a HIPAA Compliance Officer
• Have a compliance plan in place
• Continually practice and update staff training and education on HIPAA-mandated procedures
• Mitigate, respond to, and correct patient privacy and security compliance violations
• Develop and maintain open communication between patients and nursing staff
• Implement standards
• Enforce staff discipline
• Make patients aware that privacy and security policies and standards are in force and being met

Effectual and operative compliance plans reduce the likelihood of an audit by the Office of the Inspector General. It is the responsibility of practice manager overseers and doctors to ensure adequate direction is given, compliance is met and discipline is enacted when necessary, in order to maintain an effective HIPAA Compliance Program. Situations can arise, such as permitting patients' families and visitors to be present during nurse shift reporting, where the institution or facility declares the focus is on the patient not on HIPAA rules. However, in the big picture, it is the HIPAA rules that ultimately protect the patient after he or she is released. And failure to comply puts the responsibility not only on the nursing staff for its infractions but also on the institution or facility for allowing the practice to go unchecked or not monitored.

Penalties for Non-Compliance

There are fines and potential imprisonment for violating HIPAA laws. Penalties may be levied on the organization or individual or both. Fines may range from $100 to $250,000. The maximum prison sentence is ten years.

How to Support Patient Privacy

There are common scenarios where nurses may not be sure how to or if they are maintaining their patient's privacy during a routine bedside handoff. For example, a patient's spouse may be visiting when it is time for a bedside shift change. Computers and wireless devices save time when conducting a shift change handoff and may be a bit more difficult for the patient and others in the room except the operator to view, but they do not substitute for maintaining a secure patient privacy environment. Although a patient may have a private room and there are open and congenial relations between the patient and his or her spouse or others, in keeping with the HIPAA and other privacy acts, the visitor/spouse should be asked to leave the room while the shift change routine is conducted. Upon entering the patient's room with the computer, the nurse ending their shift may explain it is time for a shift change and report, introduces the next shift nurse, and asks the visitor to please wait outside (or offered to visit the cafeteria or other visitor units) until the shift handoff is concluded. The nurse then asks the patient if it they consent to the nurses openly discussing his or her care and proceed accordingly. After the handoff is concluded, the patient may be asked if he or she requires anything in particular, and the visitor is then permitted to return to the patient's room. The patient's privacy and security is respected in accordance with HIPAA and patient privacy policies. The shift change handoff and report are completed calmly and accurately, and it has little impact on the visitor(s).

Semi-private rooms present a different privacy issue since the other patient's privacy is equally important. Routinely a nurse is finishing up their rounds when the oncoming nurse appears to do the shift change handoff report. Although the patient in the semi-private room that is the concern of the report may not have visitors and shift change report may be completed quietly, the other patient in the semi-private room may have visitors. Similarly to the previous scenario, the visitors should be informed of the shift change and need for reporting and asked to please step outside the patients' room, offered a waiting area or place in the building where they may relax with a snack or purchase items their patient needs or they would like him or her to have.

After the other patient's visitors are removed, appreciation should be conveyed to the patient and the nurses may pull the privacy curtain and resume conducting the shift change handoff. Quietly the nurses discuss and electronically record their current assessment of the patient's condition, medications, and pending medical treatments. They check the patient's IV, dressings if applicable, general condition and determine and document further care, oversight, and goals. Upon completion, the privacy curtain is pulled back according to the patient's wishes and the other patient's visitors, if around, are notified they may return and continue their visit.

In another scenario, the shift change nurses encounter a patient in a semi-private room that has teenage children visiting. The nurses introduce themselves and ask if the patient consents to a beside handoff report procedure. The patient is apprehensive with her children in the room, and the nurses give the patient the option to do the handoff outside of the patient's room or the children may be directed to the cafeteria or waiting area until the shift change procedure is completed. A patient safety check, including checking the patient's IV and dressings, is routine. In some circumstances, at the patient's consent, the safety check may be performed before asking the family, spouse, or intimate visitor to exit the patient's room. Also in some cases, as part of the patient's overall care, it may be of some comfort to have a family member, spouse, or close friend present for the safety check.

Again, the curtain is pulled, the safety check is performed and the children are asked to step outside the room until the shift change handoff is completed. The patient, when alert, may review written communications about their condition and proposed changes in their care. All verbal communications are discreet.

Improving Handoff During Shift Change

Not only should HIPAA and other regulations be followed, but the patient's comfort and condition is also very important. The patient's anxiety should be minimized when possible. The patient is already compromised due to his or her condition, and any confusion, perceived threat, misunderstandings, etc. can further complicate their illness and condition.

Standardized report methods should be used to avoid losing critical data. Standardization also aids in educating new nurses in compliance and procedures. Oncoming nurses are better able to prioritize and manage their patients' care and patient loads after collaborating with the outgoing nurse and patient. Improved strategies enhance the workflow process. During the shift change process, it is important for the nurses to express and define what the patient may expect. Any particular situations such as sleeping problems, discomfort, nausea, etc. may be discussed and responded to. All behavior observed during the shift change report is confidential. All discussions between the staff and between the staff and patient are confidential. All report entries are confidential except to particular individuals such as the nurses assigned to the patient and doctors. An effective and standardized shift change report is a valuable educational and patient care guideline tool. Systemized patient interview (questions) and recorded observations should be implemented. A routine practice affords a greater sense of confidence and staff satisfaction.

It is also a recommended practice to advise the patient upon admission, when applicable, of the shift change procedure and what it will be used for, its confidentiality, and opportunity to educate both the patient and new staff. Effective communicating is at the heart of the bedside shift change report. Care, patience, observation to detail and orientation are necessary qualities. Individual components should be reinforced such as patient education and orientation, and the patient's familiarity with the staff as well as what to expect regarding their treatment. Approximately 30 to 60 minutes prior to a shift change, the patient may be informed of the impending change of nurses and answer any concerns or questions the patient might have regarding the nurse staff change. Correct solutions are a goal of the bedside check and report.