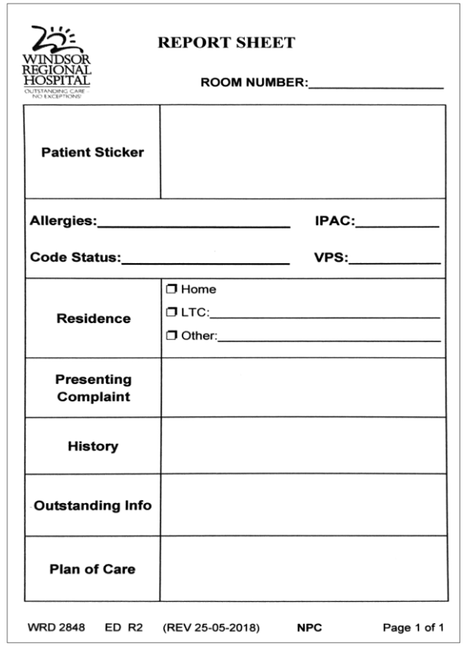
Standard Work

Job Name	Shift to Shift	Objective: Instructions on conducting shift to shift in ER	Date: October 9/18
			Owner: Emergency Department

	Process Steps	Freq
1	Initiate and use patient Report sheet at any point of nurse to nurse handover for all AC/POD ED patients. i.e. break, shift change Information on Report sheet to be reviewed with all off going and incoming nurses and during rounds	prn
2	The completed report tool is to be kept on the front of the patient clipboard. It is a working tool that will be updated throughout the patient's stay in the Emergency department. It is not part of the patient's chart. It is only a resource to communicate necessary information.	always
3	**Patient Sticker**	
	Adhere patient sticker to area indicated on tool	always
4	**Status**	
	Indicate Allergies, Code Status, IPAC, and VPS screen on report tool. Update as required.	always
5	**Residence**	
	Check box with most appropriate response regarding where patient currently resides. Update as required.	always
6	**Presenting Complaint**	
	Document the chief complaint and/or reason for presentation to the ED	always
7	**History**	
	Document medical/ applicable history of the patient	always
8	**Outstanding Info**	
	Document outstanding DI -x-rays, CT scans, Ultrasounds or other diagnostic test required Document outstanding Meds -report any outstanding medications the patient requires, BPMH Document outstanding lab- Report any tests that need to be completed. Document any relevant/abnormal labs or diagnostic results. Address labs and any required intervention. Update as required	always
9	**Plan of Care**	
	Document Plan of Care - admitted to hospital / transferred or discharged. Admitted - Document under what service and under care of which MRP If transferred - to which facility, under what services and if transportation is booked. Discharged - what follow up does the patient require, appointments made, does patient need to call for appointment, is CCAC involved in care? Can patient be discharged home safely, do they have keys, are they appropriate to be discharged home by self, is it an appropriate time of day to be discharged? Is family aware if applicable.	always
10	Admitted patients	
	If patient is admitted and is waiting to be transferred to the inpatient unit the TOA may used to provide the critical information during the shift to shift / break report	
11	ERL during shift change	
	At shift change the incoming and outgoing ERL's meet in the designated area for report At the completion of the ERL shift to shift report, conduct safety huddle with all staff Confirm nursing assignments and staffing	
12	Nursing	
	Meet in your assigned area/PODS as a team Off going shift to verbally report to oncoming shift using the updated report tool and chart for reference, the current assessment and what the oncoming shift should be looking for It is the responsibility and accountability of the oncoming nurse to ask any questions following report to clarify understanding of the information exchanged before the outgoing nurse completes report Provide the report tool to the oncoming shift/ team	
13	Post shift to shift report	
	Have a team discussion who will be the most appropriate care provider If you do not agree with the decision have a discussion with the ERL , if needed escalate to the to the CPM/OM/AHA Confirm with the RP patient assignment (does the RP have this?) Update the in room patient whiteboard	
14	During the shift	
	ERL Assist with concerns that arise during the shift Coordinate break times for all nursing staff	
	Nursing If there any outstanding issues related to patient care , clinical pathways that the nurse cannot resolve these should be escalated to the ERL/CPM/PM/AHA	

Visual Aid



WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE - NO EXCEPTIONS

REPORT SHEET

ROOM NUMBER:_____

Patient Sticker	
Allergies:_____ **IPAC:**_____ **Code Status:**_____ **VPS:**_____	
Residence	❒ Home ❒ LTC:_____ ❒ Other:_____
Presenting Complaint	
History	
Outstanding Info	
Plan of Care	

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#3 #4 #5 #6 #7 #8 #9