CHARTING AND DOCUMENTATION
A NURSING HANDOVER

Healthcare professionals write entries about patients in their care in the Patient Record. The Patient Record documents patient care and, as such, forms a permanent legal record of treatment. At the end of each nursing shift, the outgoing nurses give a verbal handover to nurses on the incoming shift. The nurses on the incoming shift are briefed on changes in patient progress and patient care. The handover is usually performed face-to-face but some institutions use recorded handovers. The information which is reported during the handover is gathered from the Patient Record, the Care Plan and any other charts which document specific patient care.

Discussion:
What do you think are the features of a good handover?
What information does not have to be repeated in a handover? Why not?
What can happen if handovers do not communicate important information from one shift to another?

Nurse: Mrs. Cho in bed number five. Mrs. Cho was readmitted yesterday because of uncontrolled hypertension. You'll probably remember her from last week. She went home but couldn't manage her ADLs herself. Her daughter had to come in every morning to give her a shower and help her during the day. She's been quite distressed about it, according to her daughter. She presented to the unit with uncontrolled hypertension despite a change in medication. She has a past history of MI this year in June. This morning, she complained of chest pain. The SHO was called. Her BP at the time, around 10 AM, was two ten over one hundred five and her pulse was one hundred. She had an ECG done and was given GTN sublingually. We gave her some Oxygen via the mask and she seemed to settle. She's in for cardiac catheterization tomorrow to assess the extent of the damage to her heart. I've booked the porter already. Strict fourth hourly obs. BP and pulse and report any chest pain immediately, of course. She's had no chest pain this shift.

What is her present medical problem?
What is her medical history?
Match the abbreviations to their meanings.

1. BP
2. P
3. qds
4. MI
5. GTN
6. SHO
7. 4°
8. c/o
9. sl
10. O_2
11. ECG
12. ADLs
13. Pt
14. obs

a) Activities of daily living
b) Four times a day
c) Senior House Officer
d) Electrocardiogram
e) Sublingual, or under the tongue
f) Myocardial infarction or heart attack
g) Blood pressure
h) Complain of
i) Observations
j) Four hourly, or every four hours; also 4/24
k) Patient
l) Glyceryl trinitrate; also called nitrolingual
m) Pulse
n) Oxygen

CHARTING AND DOCUMENTATION
A NURSING HANDOVER

A Patient Record contains entries from every member of the patient's team. As a nurse, you must read all entries in order to plan patient care efficiently. Practice giving a handover using the Patient Record.

Patient Record

U/N: 732910 **Surname: Smits** **Given names: Livia** **DOB: 10.12.31** **Sex: Female**

DATE AND TIME	Add signature, printed name, staff category, date and time to all entries MAKE ALL NOTES CONCISE AND RELEVANT Leave no gaps between entries
18.5.2012 22:30 hrs	Mrs. Smits c/o chest pain at 22:00 hrs. SHO informed. O_2 administered via a mask. BP 220/100 P 120 at 22:00 hrs. SHO ordered ECG, attended by nursing staff. GTN sl administered at 22:00 hrs, chest pain relieved within 2 minutes. J. Keene (RN) KEENE

Patient Record

U/N: 619237 **Surname: Cummins** **Given names: Fred** **DOB: 17.02.1955**

DATE AND TIME	Add signature, printed name, staff category, date and time to all entries MAKE ALL NOTES CONCISE AND RELEVANT Leave no gaps between entries
20.5.2012 15:30 hrs	Mrs. Cummins was hypertensive this am BP elevated to 180/100 and P 86 at 10:00 hrs. c/o headache . Pt. stated he had no chest pain. Given paracetamol 1g with good effect. Headache relieved. BP checked at 10:30 hrs decreased to 150/85, P 77. S. Stottle (RN) STOTTLE

Patient Record

U/N: 213498 **Surname: Lancaster** **Given names: Polly** **DOB: 14.06.1942**

DATE AND TIME	Add signature, printed name, staff category, date and time to all entries MAKE ALL NOTES CONCISE AND RELEVANT Leave no gaps between entries
20.5.2012 05:30 hrs	Mrs. Lancaster had a restless night. c/o chest pain at 02:15 hrs. Night SHO called. BP 215/105, P 92 at 02:20 hrs. ECG ordered and attended by nursing staff. O_2 via mask and GTN sl administered. BP dropped to 180/86 at 02:40 hrs. No c/o further chest pain. L. Knight (RN) KNIGHT

CHARTING AND DOCUMENTATION
A NURSING HANDOVER

Discuss the following questions:

- Are you familiar with Observation Chart? (Check the chart below)
- What are other styles of Observation Charts are you familiar with?
- Who has access to the chart?
- Who is responsible for completing the chart?

Jenny, the Ward Nurse, is handing over Mrs. Small to the afternoon shift. Read the conversation and fill in the missing information from the chart. After you have filled out the chart with the correct details, practice the handover using the completed chart. Take note of the phrases used during the handover *(increase, stabilize, decrease).*

Nurse: Now, I'll just let you know about Mrs. Small's BP. As you know, she was admitted just before 2 AM yesterday with poorly managed hypertension. She's quite elderly and trying to cope at home, but the previous medication wasn't working well for her at all. Doctor Fielding wants to put her on something else and wants to monitor her BP in hospital over three days. If you look at her Observation chart from yesterday, you'll see that she was quite hypertensive on admission. BP was one hundred and seventy three over one hundred and one, pulse eighty-six. At 6 AM her BP was about the same, one seventy-five over ninety and pulse seventy-six. During the morning shift at 10 AM she shot up to two hundred and ten over one thirty, with a pulse of a hundred and twelve. She had some chest pain, too. Doctor Fielding came up to see her about the chest pain and high BP. He did all the usual things for her ECG, GTN sublingually, and she settled a bit by 2 PM. By two, her BP was one ninety-five over ninety and her pulse was ninety-seven. I took her observation chart again at 3 PM, just before handover. She's gone down to one eighty over eighty-five with a pulse of eighty-six. Doctor Fielding's happy with that but just keep an eye on her, will you?

OBSERVATION CHART

U/N: 324710 **Surname: Small** **Given names: Gladys** **DOB: 15.11.1935**

Date	Time	T	P	R	BP	Comments	Sign name
4/3/12	02:00						J. Plant (RN)
4/3/12	06:00						J. Plant (RN)
4/3/12	10:00						J. Plant (RN)
4/3/12	14:00						J. Plant (RN)
4/3/12	15:00						J. Plant (RN)