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A Study to Determine if the Verbal Nursing Report Provided Information Necessary to Ensure Continuity of Nursing Care

Mary Kathryn Heckman
University of Colorado Boulder

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A STUDY TO DETERMINE IF THE VERBAL NURSING REPORT
PROVIDED INFORMATION NECESSARY TO ENSURE
CONTINUITY OF NURSING CARE

by

Mary Kathryn Heckman

Diploma, Reading Hospital School of Nursing, Reading, Pennsylvania, 1943

B.S., University of Colorado, 1960

A Thesis submitted to the Faculty of the Graduate School of the University of Colorado in partial fulfillment of the requirements for the Degree Master of Science

Department of Nursing

1960
This Thesis for the M.S. degree by
Mary Kathryn Heckman
has been approved for the
Department of
Nursing
by

____________________________________
Patricia Vandenberghe
Grace Toews

Date Aug 11, 1960
Heckman, Mary Kathryn (M.S., Nursing)

A Study to Determine if the Verbal Nursing Report Provided Information Necessary to Ensure Continuity of Nursing Care.

Thesis directed by Associate Professor Patricia VanderLeest and Assistant Professor Grace Toews.

The problem of this study was to determine if the verbal nursing report provided information necessary to ensure continuity of nursing care. The purposes of the study were (1) to determine through observation the information included in the nursing report; (2) to analyze the data to determine if the information given was that which would provide for continuity of nursing care; and (3) to provide data which could be used in inservice education as a means of implementing continuity of nursing care. A review of the literature was made to obtain a consensus of opinions of authorities in nursing as to what information should be included in the verbal nursing report to facilitate continuity of nursing care. The method of study was descriptive-survey, using the technique of structured observation with a check list of twenty-one items as the data-gathering tool.

The study was conducted on two medical and two surgical wards of a 320 bed university connected general hospital. Twelve nursing reports were observed, comprising a total population of 243 patients.

The data was analyzed by tabulation and categoriza-
tion and revealed that information concerning the identity and physical aspects of the patient predominated while information concerning the patient's emotional, spiritual and socio-economic aspects were rarely communicated. All nursing staff reporting for duty were present for report at all observed reports, but their presence was not utilized to give directions or create an opportunity for asking questions. The conclusions reached were that (1) the nursing reports observed did not provide information necessary for continuity of nursing care, and (2) the nurses involved in the observed reports were more aware of the physical needs of the patient than needs in other areas of his life. Recommendations made were (1) that a study be made to determine if specific facts or observations which should have been included in the report were omitted, and (2) that a study be made to determine differences in the content of the nursing report between the medical and surgical wards.

This abstract of about 250 words is approved as to form and content. I recommend its publication.

Signed
Instructor in charge of thesis

[Signature]
ACKNOWLEDGMENTS

Deepfelt appreciation is expressed to Miss Patricia VanderLeest and Miss Grace Toews who contributed valuable assistance through their suggestions and constant support throughout the entire study.
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CHAPTER I

THE PROBLEM

Introduction

The nursing report is a type of communication which is ritualistically observed at the change of each shift on every ward where patients are accommodated in a hospital. For the most part, the form of this report has been passed down through the years by word of mouth and by example. Though other nursing functions have been evaluated and redefined, little study seems to have been done on the morning, evening and night reports.

In earlier years the nursing report was important as a learning situation. The head nurse functioned also as a clinical instructor and utilized the morning report to include a ward conference or brief case study, because students were less fatigued and more available at that time of day. Jenson, in 1932 presented the morning circle, as the morning report was sometimes named in the earlier days, as a method of ward teaching. She further believed that the morning circle was an opportune time for the head nurse to read important notices regarding the ward, make assignments for the day and discuss defects in nursing
Changes in the concepts of nursing service and nursing education have brought about changes in the manner of giving nursing reports.

As the responsibility of instruction has been assumed more and more by full-time instructors, it is no longer necessary for nursing reports to include structured teaching as a major function. Ward conferences and bedside teaching have been largely relegated to the clinical instructor. However, Wayland et al pointed out that adequate reporting still is essential in a hospital because of its unique organization for service to the community on a twenty-four hours a day, seven days a week basis. Responsibility for patient care must be delegated to many people who can function adequately only if pertinent information about patients is faithfully communicated by the nurses on one tour of duty to the nurses who relieve them. Relative to this Wayland, McManus and Faddis stated that, "exchange of service reports between members of the nursing staff is an important means of ensuring continuity of performance


in the twenty-four hour period."³

Statement of the Problem

The problem of the study was to determine if the nursing reports, as given verbally by nurses at the change of shifts, provided the information necessary to ensure continuity of nursing care throughout each twenty-four hour period of the patient's stay in the hospital.

Purposes of the Study

The purposes of the study were (1) to determine through observation the information included in the nursing reports; (2) to analyze the data to determine if the information given was that which would provide for continuity of nursing care; and (3) to provide data which could be used in inservice education as a means of implementing continuity of nursing care.

Need for the Study

Though the nursing report is a tradition in nursing, few references to it were found in the literature. On nursing research, Hochbaum commented about the "inordinate amount of research on nurses at the expense of research in

³Ibid., p. 162.
nursing". In searching the literature, only one other study was found which related to the nursing report and it was not concerned with the concept of providing information for continuity of nursing care. It would appear, then, that the nursing report, a time-honored practice in nursing, would be an appropriate problem for study from the standpoint of continuity of nursing care, a concept used so frequently in the present day. Certain information about the patient needs to be disseminated in order to implement continuity of nursing care. A study of the nursing report as a vehicle for the dissemination of the information about patients seemed timely.

Scope and Limitations

The study was made of the nursing report on two medical and two surgical wards of a selected general hospital in the Rocky Mountain area. A morning, evening and night report was observed on each of the selected wards.

Limitations of the study were (1) observations were made only on selected medical and surgical wards; (2) the number of nursing reports observed was limited to a total of twelve; (3) no attempt was made to determine if specific facts or observations which should have been included were

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omitted from the nursing report; and (4) no attempt was made to evaluate the physical setting in which the report was given nor the manner in which it was given.

Definition of Terms

For the purposes of this study, the following definitions of terms were used:

- Nursing report. That exchange of information which takes place verbally at the change of shifts between the nurses reporting on duty and the nurses reporting off duty.

- Nursing care. That care given by the nurse who is "acting and interacting with the patient through physical and personal contact for his welfare, and intervening in his behalf between him and those stresses in the physical environment and in the social climate that impinge upon him".  

- Continuity of nursing care. The consistent extension of nursing care to each patient throughout the twenty-four hours of each day and from day to day.

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Organization of the Remainder of the Thesis

Chapter II consists of a survey of the literature to ascertain the traditional significance of the nursing report and to determine what authorities in nursing recommend should be included in the nursing report. Chapter III presents the methods of research and data gathering used. Chapter IV presents an analysis of the data and Chapter V contains a summary of the study, the conclusions reached and the recommendations made.
CHAPTER II

REVIEW OF THE LITERATURE

Introduction

A survey of professional literature was made to establish the background of the nursing report as a traditional function in nursing and to determine the opinions of nursing authorities as to what information should be included in verbal nursing reports so that continuity of nursing care is assured. The review included The American Journal of Nursing from 1900-1960, and the Nursing Outlook from 1953-1960, and selected articles from Hospital Progress and The Modern Hospital from 1940-1960. Pertinent textbooks on the history of nursing and the administration and practice of nursing from 1915-1960 were also reviewed.

Early References to the Nursing Report

One of the earliest references to the nursing report was made by Florence Nightingale in her letters to nurses. In a letter written July 23, 1874, she wrote,

A year hence you will tell me whether you have felt any temptation not to be quite honest in reporting cases the next morning to your Sister or Nurse: that is to say you have observed when you have not observed; to slur over things in your work because there is noone
watching you: noone but God. ¹

Two years later she again referred to nurses' reports in her letter of April 28, 1876, when she wrote, "Is it not . . . the very least of all our duties - as night nurses: to be able to give a full, accurate and minute account of each Patient [sic] the next morning". ²

The first reference which was found in the literature pertaining to nursing reports in the United States was noted in the writings of Linda Richards. In writing about Bellevue Hospital in 1873, she recorded that:

"Written night orders and reports were unknown at that time. Night nurses went on duty at 8 P.M. I was on duty at 7:30 P.M. I saw each head day nurse as she left her ward, received her orders, and transmitted them to the night nurses. In the morning I gave reports to the head nurses as they began their day duty. All this was verbal." ³

From these accounts we can see that Florence Nightingale and Linda Richards, early leaders in nursing, attached significance to complete and accurate reporting on patients.


² Ibid., p. 125.

Content of the Nursing Report

A number of the references to nursing reports are related specifically to the morning report. Taylor stated that the morning report should be approached as a learning situation and that the staff nurse and the head nurse should have an opportunity to question the night nurse. The night nurse should report in detail on the acutely ill patients, and the convalescent patients may be summarized as a group if no medications were received and they slept well. Taylor further stated that a summary of patients for surgery should be given and the patients who were discharged or who will be discharged should be reported. Specific tests and treatments should be mentioned. Specific directions for the day should be given by the charge nurse. Of the evening report, she advised that the head nurse should give the report, and, by her example, teach the staff nurse what constitutes a meaningful report. In addition to the items mentioned above, the evening report should also include a report of the results and comparative effects of hypnotics administered by the nurse the previous evening, and mention should be made of the results of tests and treatments of the past eight hours.

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Writing about the morning report, Frenay indicated that it is an educational project which provides for the head nurse an opportunity to review the patients' condition during the night and to instruct the students present at the meeting. Points of consideration to be included in the report, according to Frenay, were special problems of a patient due to age, nature of disease, social background, position or occupation. Specifically suggested were preventive aspects of nursing, opportunities for patient teaching, religious and psychological implications, and social and public health aspects.5

Writing about nursing reports in general, Wayland et al listed the specific points to be included. These were (1) the name and condition of each patient, (2) kind of day, (3) special observations and precautions, (4) individual treatments, and (5) pertinent and significant points about patients and situations in general. They suggested special mention should be made of names of patients admitted, discharged or transferred. They also stated that the head nurse or charge nurse should give directions for the day, and opportunities should be created for the staff

5Sister Mary Agnes Clare Frenay, "A Guide For the Night Nurse", Hospital Progress, 27:332, October, 1946.
to make suggestions or ask questions.  

Brown and Moody suggested that during the nursing report, each patient be identified as to room number, name, age and attending physician. They also believed that each new patient should be specially noted with a thumb-nail sketch of his history, particularly the admitting diagnosis and orders.  

Randall succinctly records in her book, Ward Administration, that:  

The day or night report must present an accurate picture of the condition of the patients on each ward. This would include information about the admissions, discharges, transfers, deaths, conditions of seriously ill patients, special treatments, as well as any unusual occurrences or accidents. The practice, however, of including such information as "comfortable day", "slept well", is a waste of time. It can be assumed that if a patient's name does not appear on this report that his condition is satisfactory.  

Amy Frances Brown indicated that the nursing report should be centered around a discussion of the changes in the condition of the various patients and that an explanation be given of the consequent adaptations of

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nursing care. Gipe and Sellew recommended that the nursing care of patients should be known in a general way to all nurses regardless of assignment.

It appeared, then, that there was general agreement among the authors reviewed that nursing reports should identify each patient by name, diagnosis, age and location on the ward, that significant facts about the physical, emotional, spiritual and socio-economic aspects of the patients' care should be reported; that special tests and treatments should be included, results of previous tests, treatments and medications should be reported; and that special mention should be made about new admissions, discharges, transfers and seriously ill patients.

Nursing Reports and Continuity of Nursing Care

The importance of the contribution of the nursing report to continuity of nursing care was attested to by various authors. Brown and Moody stated that:

Head nurses and other nurses in charge of nursing units are cognizant of the importance of reports on the patient's condition; the treatments to be carried

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out, and other information necessary for the continuity of good nursing care. Nursing directors and supervisors concur that continued good care is dependent upon the transmission of complete and useful information from nursing crew to nursing crew.  

Barrett stated that the purpose of the interval report was to provide a means of transferring pertinent information about patients, and Taylor maintained that good reporting provided a pattern of care and treatment which was continuous and logical in the thinking of the staff. Gipe and Sellew reiterated this when they said that, "the purpose of reporting is to give the persons receiving the report: (1) information which is essential to their work (2) data on which there may be questions, for example, a minor mistake, accident or criticism by patients or physicians".

It can be noted from these references in the literature that there was agreement among writers that nursing reports, well organized, make a positive contribution to continuity of nursing care.

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11 Brown and Moody, op. cit., p. 91.
13 Taylor, op. cit., p. 91.
14 Gipe and Sellew, op. cit., p. 217.
Summary

The survey of the literature established that Florence Nightingale and Linda Richards, some of the earliest leaders in recorded nursing history, considered it a part of nursing responsibility to be able to give a minute and accurate account of each patient when reporting off duty. It also was established that the nursing report should identify each patient by name, age, diagnosis and location on the ward, and that it should contain significant facts about the patients' physical, emotional, spiritual and socio-economic aspects. Special mention should be made about tests, treatments, admissions, discharges, transfers and seriously ill patients. All nursing staff should be present for the report, opportunity should be provided to ask questions, and directions for the tour of duty should be given. It was further established that well-planned nursing reports are an important factor in continuity of nursing care.
CHAPTER III

METHODOLOGY

The problem of the study was to determine if the nursing reports, as given verbally by the nurses at the change of shifts, provided the information necessary to ensure continuity of nursing care throughout each twenty-four hour period of the patient's stay in the hospital.

The Method

The descriptive survey method was selected for use in the study. As enumerated by Good, the purposes of the descriptive-survey investigations were:

1. To secure evidence concerning the existing situation or current condition.

2. To identify standards or norms with which to compare present conditions, in order to plan the next step.

3. To determine how to take the next step.¹

He also stated that while criticism has been directed toward this method of research, descriptive studies can provide essential knowledge about the nature of objects,

events and persons.  

The Technique for Gathering Data

Various techniques were available for use in the descriptive-survey method of research. For the purposes of this study, the technique of observation seemed most appropriate. Of the various types of observation, direct structured observation was employed to gather the data because the study is started with relatively specific formulations. The observer is in a position to set up in advance the categories in terms of which he wishes to analyze the situation.  

All authorities consulted agreed that the presence of an observer who records the action of the group may introduce bias or distortion to the content. Since the study aimed only at ascertaining the content of the nursing report rather than the social interaction of the group, it was believed that there was less possibility for introducing bias or distortion.

\(^2\)Ibid.

Setting of the Study

The study was conducted in a 320 bed university connected general hospital in the Rocky Mountain area. Two medical and two surgical wards were used. A morning, evening and night report was observed on each of the selected wards, comprising a total of twelve reports. A total population of 243 patients was represented in the study.

Approval for the Study

The director of the nursing service of the selected hospital was contacted for permission to conduct the study. In a personal interview the study was explained and verbal permission was obtained to observe a sampling of nursing reports on the medical and surgical wards. A letter requesting permission to conduct the study was sent to the director of nursing service who acknowledged the request by granting permission in writing. A copy of both letters are included in Appendix A.

Development of the Data-gathering Tool

From the review of the literature a list of twenty-one essential items to be included in the nursing report was formulated. Eighteen of these items pertained to the individual patient and three of the items pertained to the nursing report itself. Only the items essential for continuity
of nursing care were included. The selected items represented the consensus of opinions of authorities in the nursing literature reviewed.

A check list was developed and the items pertaining to the individual patient were assigned to eighteen columns, and the three items pertaining to the nursing report were constructed in question form and included on the form with the check list.

Item One established the census, identifying the patients by number, starting at one and numbering consecutively to include the total population of the ward.

Item Two: Name
Item Three: Diagnosis
Item Four: Age
Item Five: Location on ward

Items Six and Seven referred to the patient's condition and were respectively labeled general condition and kind of day. While the information elicited by these two items is similar, they both were included because they were mentioned in the literature. Items Eight through Eleven were specific types of significant facts about the patient and were defined as follows:

Item Eight: Physical fact. Pertaining to organic or physiological problems and/or needs of the patient.

Item Nine: Emotional fact. Pertaining to mental
health aspects and behavioral needs and/or problems of the patient.

Item Ten: Spiritual fact. Pertaining to the patient's need for religious ministrations and understanding.

Item Eleven: Socio-economic fact. Pertaining to the environment of the patient and his adjustment to his environment, such as problems in self-care, health teaching of patient and family, plans for discharge, problems in finances and a place to live.

Item Twelve, special tests, referred to any information given in the nursing report about special tests, such as a kidney function test or a fractional gastric analysis.

Item Thirteen, special treatments, referred to any mention of special treatments to be administered to the patient, such as physical therapy or special procedures prior to surgery such as enemas until clear.

Item Fourteen: Results of tests, treatments or medications during the past eight hours.

Item Fifteen: Special mention if patient was newly admitted.

Item Sixteen: Special mention if patient was to be discharged.

Item Seventeen, seriously ill, referred to mention of the fact that the patient was placed on the seriously
ill list by order of the doctor.

**Item Eighteen**, staff-patient relationships, pertained to the reporting of any incidents in the relationship between the patient and the nursing staff.

**Items Nineteen through Twenty-one** were the questions to be answered by a yes or no, and were as follows:

**Item Nineteen**: Did charge nurse give directions for the shift?

**Item Twenty**: Was opportunity provided for questions from the staff?

**Item Twenty-one**: Was all nursing staff present?

Thus a check list was constructed from these twenty-one items pertinent to continuity of nursing care which should be included in the nursing report when applicable.

**Validity of the Data-gathering Tool**

According to Hawkins, "empirical validity is that sort attained by submitting beforehand to the standard of consensus".\(^4\) He further stated that when a set of items constitutes a definition of some common experiences, then the conjuncture of these items is a solid instrument for measuring the phenomenon under study.\(^5\) It was believed

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\(^5\) Ibid.
that the validity of the check list for this study was established in this manner.

The Pilot Study

A pilot study was made to determine if the check list as developed permitted identification and categorization of the content of the nursing report and to ascertain if the data obtained could be analyzed. The pilot study was made on two medical wards and one surgical ward of the selected hospital. Three reports, one each of the morning, evening and night reports, were observed. A total patient population of fifty-nine was included in the pilot study. The pilot study indicated that the content of the nursing report was adaptable to identification and categorization according to the items on the check list, and that the data could be analyzed. No revisions were deemed necessary and the check list was approved for use. The data obtained from the pilot study was included in the larger study. The check list in its entirety is included in Appendix B.

The Larger Study

A morning, evening and night report was observed on each of the selected wards. This included the observations made during the pilot study and added up to a total of twelve observations. The nursing reports observed were
selected randomly without a prearranged schedule and without advance notice to the wards. All observations were made by the investigator using the check list in each case. The groups were not told what aspects of the nursing report were under observation, but they were aware of the fact that the investigator was conducting a study. The investigator joined the groups receiving the nursing reports as a non-participant observer after obtaining permission to observe the report from the charge nurse in each instance. In recording the observations, the quality or pertinence of the reported events was not taken into consideration. The reported events were only identified and checked in the appropriate columns.

In studying the data, the technique of analysis used was categorization and tabulation.

Summary

The research method most applicable to this study was the descriptive-survey. The technique which best met the needs of the study's purpose was structured observation. The study was conducted in a university connected general hospital on two medical and two surgical wards. Permission for the study was obtained from the director of nursing service of the selected hospital. The data-gathering tool was a check list of twenty-one items. A pilot study of
three observations was made on two medical wards and one surgical ward to test the check list. No revision of the check list was deemed necessary; it was approved for use and the data collected was used in the larger study. The larger study was conducted on the two medical and two surgical wards and consisted of the nine remaining observations. The data obtained from the study is presented and analyzed in Chapter IV.
PRESENTATION AND ANALYSIS OF THE DATA

Introduction

An analysis of the data was made to determine if the verbal nursing report furnished information necessary to ensure continuity of nursing care.

Twenty-one items, eighteen items pertinent to the individual patient and three items relating to the nursing report itself, comprised the check list and were checked by the investigator as a basis for observation. Twelve nursing reports were observed on two medical and two surgical wards. A total population of 243 patients was included. The data was categorized and tabulated.

Tabulation of the Data

Item One established the population of 243 patients on the two medical and two surgical wards used in the study.

The remaining seventeen items pertinent to the individual patient were checked according to the frequency with which they were mentioned in the nursing report. Of these seventeen items, Items Two through Eleven were calculated in percentages and number of times present in the
content of the nursing report because it was believed those items were applicable to all patients. Items Twelve through Eighteen were calculated only according to the frequency with which they were mentioned in the nursing report because it was believed they were not applicable to every patient. Items Nineteen through Twenty-one related to the nursing report itself and were constructed in the form of questions to be marked yes or no.

**Items Applicable to All Patients**

**Item Two:** Name. The patient's name was mentioned two hundred and forty-three times, or for 100 per cent of the population.

**Item Three:** Diagnosis. The diagnosis was mentioned one hundred and ninety-four times, or for 80 per cent of the population.

**Item Four:** Age. The age was mentioned forty-eight times, or for 20 per cent of the population.

**Item Five:** Location on the ward. The location of the patient was mentioned forty-seven times, or for 19 per cent of the population.

**Item Six:** General condition. The general condition of the patient was mentioned forty-one times, or for 17 per cent of the population.

**Item Seven:** Kind of day. Kind of day was mentioned eighty-one times, or for 33 per cent of the population.
Item Eight: Physical facts. Physical facts were mentioned two hundred and ten times, or for 86 per cent of the population.

Item Nine: Emotional facts. Emotional facts were mentioned thirty-three times, or for 13 per cent of the population.

Item Ten: Spiritual facts. Spiritual facts were not mentioned at any of the observed reports.

Item Eleven: Socio-economic facts were mentioned four times, or for 1.6 per cent of the population.

Items Not Applicable to All Patients

Item Twelve: Special tests. Special tests were mentioned for eighteen patients.

Item Thirteen: Special treatments. Special treatments were mentioned for fifteen patients.

Item Fourteen: Results of tests, treatments or medications past eight hours. One or more of these facts were mentioned for eighteen patients.

Item Fifteen: Newly admitted patients. That a patient was newly admitted was mentioned fifteen times.

Item Sixteen: Patients to be discharged. Mention of patients to be discharged was included in the report seven times.

Item Seventeen: Seriously ill patients. That a patient was seriously ill was mentioned fourteen times.


Item Eighteen: Staff-patient relationships. On two occasions staff-patient relationships were brought into the nursing report.

Items Relating to the Nursing Report

Item Nineteen: Does the charge nurse give directions for the shift? On one occasion out of twelve observations the charge nurse gave directions for the shift.

Item Twenty: Was an opportunity provided to ask questions? On one occasion out of twelve observations opportunity to ask questions was provided.

Item Twenty-one: Was all nursing staff present? For all twelve observations all nursing staff reporting on duty was present.

Interpretation of the Data Obtained

From the Check List

The review of the literature established the fact that good reporting provided a pattern of care and treatment which was continuous and logical. As defined in the study, nursing care was acting and interacting with the patient through physical and personal contact for his welfare, and intervening in his behalf between him and those stresses in the physical environment and in the social climate that impinge upon him.
Analysis of Items Applicable to All Patients

It cannot be said that the pattern of reporting established by the twelve nursing reports observed provided information for continuous nursing care when there was a preponderance of information concerning the name, diagnosis and physical aspects of the patient and a dearth of information relating to his age, location, condition, kind of day and facts concerning the emotional, spiritual and socio-economic aspects of the patient.

If the items comprising the check list are those which facilitate continuity of nursing care, then the kinds of information embodied in these items must be relayed from shift to shift.

The present concept in nursing involves the total patient and his environment and all his stresses, problems and needs. With this concept in mind, it was of interest to note that the analysis of data revealed that of the items applicable to all patients, only 43 per cent of the essential information necessary to facilitate continuity of nursing care was given.

The patient's name was mentioned for 100 per cent of the population, the diagnosis was mentioned for 80 per cent of the population. Of the remaining information considered essential for the identity of the patient, age was mentioned for only 20 per cent of the population and location
on the ward was mentioned for only 19 per cent of the population. Of the information indicating the patient's actual condition, general condition was mentioned for only 17 per cent of the population and kind of day for only 33 per cent of the population. Of the significant facts relating to various aspects of the patient, physical facts were mentioned for 86 per cent of the population, far outweighing the emotional facts, mentioned for only 13 per cent of the population, and socio-economic facts which were mentioned for only 1.6 per cent of the population. It is worthy of special comment that facts about the spiritual aspects of the patient were not mentioned at any of the observed nursing reports.

**Analysis of Items Not Applicable to All Patients**

*Items Twelve through Eighteen* did not lend themselves to interpretation and were tabulated only. However, it was interesting to note that these items had a more consistent representation in the content of the nursing report than some of the items considered essential for and applicable to all patients. In view of the fact that nursing care involves acting and interacting with the patient, it also was interesting to note that staff-patient relationships were mentioned for only 1.6 per cent of the population.
Analysis of Items Related to the Nursing Report

Data from Items Nineteen through Twenty-one revealed that it was considered important in all twelve observations to have all nursing personnel reporting for duty present at report, but in only one instance was their presence utilized by the charge nurse to give directions and share other communications with the staff. Opportunity for questions from the staff was observed in only one case even though there was wide agreement among nursing authorities in the literature that this was an important aspect of the nursing report.

Summary

The analysis of the data revealed that the nursing reports observed did not provide adequate information to ensure continuity of nursing care according to the items formulated from the consensus of opinions of the nursing authorities consulted in the review of the literature. The data indicated that most of the information provided in the nursing report concerned the identity and physical needs of the patient and that facts concerning the emotional, spiritual and socio-economic needs and problems of the patient were seldomly communicated. It also revealed that while all of the nursing staff reporting on duty were present for the nursing report, their presence was rarely
utilized to give directions or share communications, and opportunities for the oncoming staff to ask questions were rarely provided.
Summary

The problem of the study was to determine if the nursing reports, as given verbally by the nurses at the change of shifts, provided the information necessary to ensure continuity of nursing care throughout each twenty-four hour period of the patient's stay in the hospital.

A review of the literature was done to establish the background of the nursing report as a traditional function in nursing and to determine the consensus of opinions of authorities in nursing as to what information should be included in the verbal nursing reports to facilitate continuity of nursing care.

The descriptive-survey method of research was selected for the study, using the technique of structured observation. The data-gathering tool was a check list of twenty-one items constructed from the information necessary to be included in the nursing report to ensure continuity of nursing care. The first eighteen items were assigned to eighteen columns. Item One established the census; Items Two through Eleven were the items applicable to all patients; Items Twelve through Eighteen were the items applicable to certain patients; and Items Nineteen through
Twenty-one applied to the nursing report itself and were constructed in question form and were part of the check list. The check list was used as a basis for observation and the items were checked by the investigator according to the frequency of their occurrence in the content of the nursing report without regard to quality or pertinence.

The study was conducted on two medical and two surgical wards of a university connected hospital in the Rocky Mountain area. The total population was comprised of 243 patients.

The analysis of the data revealed that the twelve nursing reports observed did not provide adequate information to ensure continuity of nursing care. The information most frequently communicated was name, diagnosis and physical facts concerning the patient, and the information least frequently communicated concerned the patient's age, location, condition and facts about the emotional, spiritual and socio-economic aspects of the patient. With the present day concept of total patient care in mind, it was of noteworthy interest that information concerning the identity and physical aspects of the patient predominated while information concerning the patient's emotional, spiritual and socio-economic aspects were rarely communicated. Of the nursing report itself, it was felt important at all twelve observed reports to have all nursing staff reporting
for duty present at report, but directions for the shift and
opportunities for questions, which were also considered im-
portant by nursing authorities in the literature, were ob-
served at only one report.

Conclusions

On the basis of the data obtained in the study, the
following conclusions were made:

1. Since the analysis of the data obtained from the
study indicated that of the items applicable to all pa-
tients, only 43 per cent of the essential information neces-
sary to facilitate continuity of nursing care was given, it
can be concluded that the twelve nursing reports observed
did not provide information necessary to ensure continuity
of nursing care.

2. On the basis of the twelve nursing reports ob-
served which indicated a preponderance of information con-
cerning the identity and physical aspects of the patient,
it would appear that the nurses involved in the observed
reports were more attuned to understanding and ministering
to the physical needs of the patient than to understanding
and handling problems and needs of the patient in other
areas of his life, such as the emotional, spiritual and
socio-economic aspects.
Recommendations

The following recommendations were made as a result of the data obtained in the study:

1. That a study of the nursing report be made to determine if specific facts or observations which should have been included in the report were omitted.

2. That a study of the nursing report be made to determine differences in the content of the nursing report between the medical and surgical wards.

Other Recommendations

Other recommendations made were:

1. That studies of nursing functions be made with the purpose in mind of bringing the traditional functions of nursing into harmony with the present day concepts of nursing.

2. That a study be made to determine if good communication between nurses is a factor in eliminating repetitious activity and dealings with patients.

3. That the function and organization of the nursing report should be included in the inservice education program of the hospital and that the head nurse should be carefully oriented as to what constitutes a meaningful report.
BIBLIOGRAPHY
BIBLIOGRAPHY

Books


**Periodicals**


APPENDIX A

Letters
June 2, 1960

Mrs. Louverta Brunkow
Director of Nursing Service

Denver, Colorado

Dear Mrs. Brunkow:

I am a student at the University of Colorado Graduate School, Department of Nursing. For my thesis problem I have selected to determine if the nursing reports, as given orally by nurses at the change of shifts, furnish the information necessary to provide for continuity of nursing care throughout each twenty-four hour period of the patient's stay in the hospital.

I would like to conduct the study on selected medical and surgical wards. It will entail making observations of a sampling of nursing reports at the morning, afternoon and night shifts. May I have your permission to conduct my study at ____________________ Hospital?

The hospital will not be identified in the study. If you desire, I would be happy to give you a report of the findings of the study at its completion.

Sincerely yours,

Mary K. Heckman
July 20, 1960

COPY

Miss Mary K. Heckman
1836 South Pearl Street
Denver 10, Colorado

Dear Miss Heckman:

You are hereby granted permission to collect the data for your thesis at ________________________________

Since all theses are available to us in the library, it will not be necessary for you to give us a report of the findings.

Sincerely yours,

(Mrs.) Louverta Brunkow, R.N.
Acting Administrator
Nursing Services

LB: tr
APPENDIX B

Check List
| 19. | Charge nurse gives direction for the shift. Yes ___ No ___ |
| 20. | Opportunity is provided for questions from staff. Yes ___ No ___ |
| 21. | All nursing staff reporting for duty are present. Yes ___ No ___ |