uses a multidisciplinary approach to planning and documenting client care, using critical pathways, and it is most effective when there is a predictable outcome. These forms identify the outcomes that certain groups of clients are expected to achieve on each day of care, along with the interventions necessary for each day. See Chapter 7 for more information about critical pathways and case management. See Appendix II for a sample critical pathway.

Along with critical pathways, the case management model incorporates graphics and flow sheets. Progress notes typically use some type of charting by exception. For example, if goals are met, no further charting is required. Goals that are not met are called variances. Deviations or variances are unexpected occurrences that affect the planned care or the client’s responses to care. When a variance occurs, the nurse writes a note documenting the unexpected event, the cause, and actions taken to correct it. Or, the note may justify the actions taken. See Table 11-4 for an example of how a variance might be documented.

The case management model promotes collaboration and teamwork among caregivers, helps to decrease length of stay, and makes efficient use of time. Because care is goal focused, the quality may improve. However, critical pathways work best for clients with one or two diagnoses and few individualized needs. Clients with multiple diagnoses (e.g., a client with a hip fracture, pneumonia, diabetes, and pressure sore) or those with an unpredictable course of symptoms (e.g., a neurologic client with seizures) are difficult to document on a critical path.

**TABLE 11-4**

**Example of Variance Documentation (Portion of a Critical Pathway)**

An elderly client has had a below-the-knee amputation. On the third postoperative day he has a temperature of 102°F (38.8°C). Lung sounds are clear and he is not coughing. The nurse notices redness and skin breakdown over the client’s sacrum. The critical pathway outcomes specified for Day 3 are “Oral temperature <100°F (37.7°C) and “Skin intact over bony prominences.” The nurse should chart the following variances:

<table>
<thead>
<tr>
<th>DATE/TIME</th>
<th>VARIATION</th>
<th>CAUSE</th>
<th>ACTION TAKEN/PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/16/07</td>
<td>Elevated temperature</td>
<td>Possible sepsis</td>
<td>4/16—Blood cultures 33 per order. Monitor temp. q1h. Monitor I&amp;O, hydration, and mental status.</td>
</tr>
<tr>
<td>0900</td>
<td>Impaired skin integrity: pressure sore on sacrum</td>
<td>Client not moving about in bed unless reminded</td>
<td>4/16—Positioned on L side. Turn side-to-side q2h while awake. On every client contact, remind client to move about in bed. Apply Duoderm daily after bath.</td>
</tr>
</tbody>
</table>

**CHANGE-OF-SHIFT REPORTS**

A change-of-shift report is a report given to all nurses on the next shift. Its purpose is to provide continuity of care for clients by providing the new caregivers a quick summary of client needs and details of care to be given.

Change-of-shift reports may be written or given orally, either in a face-to-face exchange or by audiotape recording. The face-to-face report permits the listener to ask questions during the report. Written and tape-recorded reports are often briefer and less time consuming. Reports are sometimes given at the bedside, and clients as well as nurses may participate in the exchange of information. See Box 11-3 for key elements of a change-of-shift report. Also see information on reporting in Chapter 49.

**TELEPHONE REPORTS**

Health professionals frequently report about a client by telephone: Nurses inform physicians about a change in a client’s condition; a radiologist reports the results of an x-ray study; a nurse may confer with a nurse on another unit about a transferred client.

The nurse receiving a telephone report should document the date and time, the name of the person giving the information, and what information was received, and should sign the notation. For example:

\[\text{[date]} \ 10:35 \text{ A.M. GL Messina, laboratory technician, reported by telephone that Mrs. Sara Ames’s hematocrit was 39/100 mL. _______ Barbara Ireland, LPN}\]

If there is any doubt about the information given over the telephone, the person receiving the information should repeat it back to the sender to ensure accuracy.

When giving a telephone report to a physician, it is important that the nurse be concise and accurate. Begin with name and relationship to the client (e.g., “This is Jana Gomez; I’m calling about your patient, Dorothy Mendes. I’m her nurse on the 7 P.M. to 7 A.M. shift.”).