Daily Documentation Reminders:

- Complete start of shift and end of shift chart checks
- Visual chart checks need to be done q 1 hour per Hospital Standards (use tracking board)
- Baseline assessment and plan of care documentation
- Documentation of reassessments based on level of care (i.e. ICU, Med Surg)
- Daily Weight (confirm it has been completed)
- Patient Education
- Nursing Narrative Form (if change in condition, transfer etc.)
- Review Multidisciplinary Discharge Planning Form
- RN Co-Signature Form (if covering student, GN, LPN, float)
- Nursing Admission History Form (confirm it has been completed)
- Document all Critical Lab Values
- Complete Nurse Review at least q 4 hrs
- Complete any tasks on Task List and PAL including Infusion Billing Documentation:
  - Frequently review eMAR for any due medications
  - Check that all Intakes have been confirmed on I&O band
Report Content and Process:
Requires participation from both oncoming and off-going nurses
- Full 21 Point report including pain assessment (5th VS)
- Run lines at bedside
- Review all drains, tubes, wounds at the bedside
- Neuro exam for pt. w/compromised neuro status – both nurses participating
- Update the white board with the plan of care, names etc.

Computer Chart Checks & Bedside Report:
To be done by BOTH on coming and off going nurses during shift change.
- Both nurses need to check the PAL to ensure that:
  ✓ There are no overdue medications
  ✓ All tasks have been completed on the task list
  ✓ No outstanding orders that still need reviewing
- Review that all Intakes have been confirmed on I&O band
- Review Power Orders for planned state orders that may need to be initiated
- If there are uncompleted tasks, orders not reviewed, or overdue medications, then a brief report needs to be given, including a reason.