GUIDELINES FOR SHIFT REPORT

A. Patient name, age, room #, diagnosis, how injured.
B. Code status or special needs (blind, deaf, HOH, etc.)
C. Assessment data:
    a. Abnormal vital signs
    b. Objective data/measurements made during your shift
    c. Skin assessment
    d. Any change in condition
    e. Any new information by patient, family or health care team members.
    f. I & O (if pertinent), bowel results and ICP results
    g. Any new lab and/or diagnostic test results
    h. Accucheck results
    i. Diet
D. Interventions:
    a. Wound care/dressing changes
    b. PRN medications given and times during your shift
    c. Any new MD consultations
    d. Recent/new orders
E. Patient/family teaching done
F. D/C plans
G. Priorities or things to follow up for oncoming RN:
    a. Report on immediate treatment plan for newly admitted pt.
    b. Report any specific prep activities for patients undergoing diagnostic or operative procedures
    c. Report on condition of patient returning from diagnostic or operative procedures

Do not read the Kardex. The oncoming shift will receive a current printed copy and can refer to during report.