

Hospital Daily Ward Checklist

Daily Operations | US

UNIT / FLOOR	DATE ___ / ___ / ____	SHIFT	CHARGE NURSE
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PATIENT SAFETY

- | | |
|--|---|
| <input type="checkbox"/> Two-identifier patient ID check done
<small>Joint Commission NPSG.01.01.01</small> | <input type="checkbox"/> Allergy alerts on wristbands and chart |
| <input type="checkbox"/> Fall risk assessments current | <input type="checkbox"/> Isolation precaution signage posted |
| <input type="checkbox"/> Bed alarms set for at-risk patients | <input type="checkbox"/> Restraint orders current (if any) |
| <input type="checkbox"/> Call lights within reach, all beds | <input type="checkbox"/> Patient whiteboards updated |

MEDICATION & SUPPLIES

- | | |
|---|---|
| <input type="checkbox"/> Medication cart locked and stocked | <input type="checkbox"/> Clean linen supply adequate |
| <input type="checkbox"/> Controlled substance count verified
<small>Two-nurse count, sign narcotic log</small> | <input type="checkbox"/> PPE stock at dispensing stations |
| <input type="checkbox"/> Crash cart checked and sealed
<small>Verify defibrillator charge daily</small> | <input type="checkbox"/> Hand sanitizer dispensers filled
<small>CDC hand hygiene compliance</small> |
| <input type="checkbox"/> Sharps containers below fill line | <input type="checkbox"/> Specimen collection supplies stocked |

EQUIPMENT STATUS

	OK	FAULT	N/A		OK	FAULT	N/A
Vital signs monitors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pulse oximeters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IV infusion pumps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Blood pressure cuffs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suction equipment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thermometers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oxygen flow meters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Wheelchairs / mobility aids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ENVIRONMENT OF CARE

- | | |
|--|---|
| <input type="checkbox"/> Hallways clear of obstructions | <input type="checkbox"/> Room temperatures comfortable |
| <input type="checkbox"/> Wet floor signs placed where needed | <input type="checkbox"/> Lighting functional in all areas |
| <input type="checkbox"/> Emergency exits unobstructed | <input type="checkbox"/> Nurse call system tested |

SHIFT HANDOVER NOTES

Patients requiring close monitoring

Pending results or procedures

Charge nurse signature _____

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Notes

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