

Episode 012

Nursing Report for Newbies

This episode discusses the basic nursing considerations for report, including etiquette, LDA's, meds, concerns for the health care team, and alarms

What it is

- Report is a fast paced information sharing time between shifts
- You're quickly learning about each patient and what you need to do for the next shift (typically 12 hours)
- Report looks different for different unit - your expectations should be different
- The ED RN's give each other reports very different from the ICU's and the floors. The ED is VERY focused on the specific problem at hand. The ICU is extremely detailed. The floor is somewhere in between. Therefore, if you're in the ICU getting report from the ED, the report is going to be a lot shorter and more concise, focused on only a few key things and tasks
- The off-going nurse reports off to the oncoming nurse in a systematic way
- **TIP!** When deciding on a report sheet, give yourself some time with each sheet. You need to learn the sheet a little bit and where things are to see if it fits your needs.
- **TIP!** Approach it like a golf swing, do it the same way every time

Report etiquette

The person giving report will go through their report and afterwards, the person receiving report asks questions.

- **Do not ask questions to receive each piece of information.** Allow the off-going nurse to give a full report, then ask clarifying questions. Report takes substantially longer if the off-going nurse is continually interrupted. Ask questions if you absolutely must during, but try to save most for the end.
 - Talking point: "Can you hold off questions until I'm done? I promise I'll answer that."
- **Don't get too focused on filling out each box in your report sheet.** Patients are dynamic and different, so not every box may be necessary... and you may waste time trying to find irrelevant and/or unnecessary info just to fill every single one out.
 - The offgoing nurse's job is to paint a clinical picture, not ensure the oncoming nurse's report sheet is filled out perfectly
- **Report is a time for the off to share information and paint a clinical picture of the patient.** It is an ineffective use of time to go through the chart and verbalize everything the oncoming nurse can just plainly see. Communicate the important things and describe the clinical picture.
- **Don't be a jerk.** If report was too concise or not comprehensive enough, don't hate on the person. Or if there are tasks that weren't done that you think should have been.
- **How to handle orders placed at or around shift change:**
 - Typically, if an order is placed at shift change, it's the oncoming nurse's responsibility to complete it. Nursing is a continual process, and while we'd like to pass our patients off all neat and tidy with everything done all the time, the reality is that doesn't always happen.
 - Remember, things happen at shift change, or things happen earlier and prevent the off-going nurse from being timely with everything.
 - Have some grace and understanding, but also be able to verbalize when you think something should have been done.
 - Talking point: "Hey if you could give that scheduled heparin that was an hour ago before you leave, that'd be great. Thanks."

Basic report information

It's really important to review the chart while going through report, so that means focusing on nursing orders – making sure things that should have been done are completed and all of your questions are answered.

Things to write down when getting report (this is incredibly general and will vary if you're on a specialized unit):

- Name / MD's / Code status / allergies
- Precautions (fall, seizure, infection prevention, bleeding, etc.)
- Chief complain / why they're in the hospital and important things that have happened during the admission
- Pertinent history (it'll take time to figure out what pertinent and not, don't get hung up on this one. You'll also figure out, with time, shorthand/abbreviations for history)
- Abnormal assessment findings from body systems
- If they're on oxygen and how much via which delivery method (nasal cannula, face mask, non-rebreather, etc.)
- Any tubes (feeding tubes, foley catheter, rectal tube, etc.)
- Intravenous access (IV, central line, port, etc.)
- IV fluids / drips / anything continuously infusing
- Activity level / how they go to the bathroom
- Pertinent / abnormal labs
- Questions to ask MD / questions for any other member of the health care team
- Any psychosocial / family + support system concerns
- Important meds (you can look up this stuff in the chart, but they may mention some meds)
- Any tests, procedures, transfers, etc. that need to occur during this shift
- General discharge plan / what are our goals this shift? (get out of bed 3 times, eat, pass swallow evaluation, transfer out of ICU, etc.)

More resources

- [The Ultimate Nursing Brain Sheet Database \(33 free nurse report sheet templates\)](#)
- [The Ultimate Guide to Creating an ICU Report Sheet \(for new critical care nurses\)](#)
- [NCLEX Prep Podcast: Giving and Receiving Report](#)
- [Nursing Report Sheet Template and NRSNG Podcast Episode: OMG Please Don't Make Me Take Report From Him!](#)