



# What Should I Share?

## Quick Reference for Precepting/Guiding New to Neuro or Care Unit

This quick reference represents common topics, questions and concerns voiced during orientation. It is intended to support nurses who are precepting nurses unfamiliar with the care of the neuro patient or the environment of care. Ex. Floating, travelers, new to neuro. The reference is not all encompassing and should be used to supplement the care unit's information.

### GENERAL KNOWLEDGE

<b>Introduction to unit</b>	Intro to nursing colleagues, expectations, culture of unit. Assignments, Report times, Support staff. Communication systems, physical layout
<b>Nursing Structure: Who are the "Go To" Leadership</b>	Who to go to for unit questions, issues, concern? Nurse Manager? Charge Nurse? Preceptor? Staff? <b>When do you want to hear about an issue or problem?</b> Ex. Patient changes, patient travel decisions? Problems with time management? Feeling overwhelmed? Coverage for lunch /break?
<b>Communication structure?</b>	Communication systems, Report times, Bedside report? Team rounding nursing attendance & role, family included in rounds? Family communication/visitation?
<b>Emergency response</b>	Code, Fire, Security, Rapid Intubation, Seizure, Neuroemergencies
<b>Resources -Collaborative team</b>	Review Physician/APP team? What team covers his/her patients <b>What's the nurse's role in rounds?</b> Rounding times Nursing assistants? Roles and responsibilities? Collaborative teams- Respiratory therapy,PT,OT,Speech,Pharmacist,Social Worker,Case Management, Chaplain, IV team <b>Do they start own IV's, blood draws?</b>

### PATIENT CARE

<b>Receiving &amp; Giving Report</b>	<b>Role model the information expected &amp; setting nursing goals for the shift.</b> Review knowledge of swallow screen, NIH stroke scale, (who will do it if they are not certified?) documentation system.
<b>Report Examples</b>	Patient history, current concerns, neuro exam/vital signs risk for deterioration? Current goals of care. Medication management, swallow screen results (if applicable) hemodynamic goals, lines, drains, monitoring used, family spokesperson.
<b>Neuro Exam Report</b>	<b>Report should always include detailed info about neuro exam. Is the patient at risk for deterioration?</b> What to watch for? Is it the same as the previous nurse's findings? Any interventions, testing etc. Demonstrate the expected neuro exam How often is the exam performed? <b>Caution the nurse to always report any suspected changes or questions about findings to the charge nurse or designated staff.</b>

## GENERAL CARE

### Safety Care

#### Review Common practices

Mobilization plan- Can patient be mobilized, HOB orders. PT role  
Restraint policy, behavior plan?, nurse observers available? Security button in room?  
Swallow screen status, dietary need? Can aide help feed?  
Skin- turning practices, wound nurse available?

### Transfer to floor or facility/Discharge home

#### Time expectations from order to the transfer or discharge? Plan?

Case management role?  
Documentation requirements  
Report/pass off structure?

### Post Op Admissions

#### Review Report from OR/procedure- Ask about deterioration risk?

**Post Op Care-** Neuro exam( specific to neuro diagnosis & treatment), vital sign intervals , pain management, wound care.

### General Admission

**Expectations of nursing role?** report to the nurse from sending team? admission documentation? Order writing responsibilities, testing ordered?

### Intrafacility Transport

What is important for your trainee to know about keeping neuro patients safe during transport? Where are the facility's transport policies located?