Communication

And The Future Health Professional

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How do I record and report?

- As a future health professional, you must record and report all observations while providing care
- Must listen to what patient is saying, but observe other senses as well
- Senses:

  -Smell: Patient's body or breath odor

  -Sight: Changes in patient's appearance

  -Hearing: Patient's words, tone and breathing

  -Touch: Patient's skin and pulse

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Observation

- Two types:

Subjective

- Cannot be seen or felt
- Commonly called symptoms
- Usually statements or complaints made by patient/resident
- Report in exact words

Objective

- Can be seen or measured
- Commonly called signs

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Things to Remember

- Written observations must be accurate, concise and complete as well as neat and legible
- Spelling and grammar should be correct
- Only objective observations should be noted
- Subjective data that the health care worker feels or thinks should be avoided
- Errors should be crossed out neatly with a straight line, have "error" recorded by them, and initials of the person making the error

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Telephone Communication

- Be cheerful when greeting a caller
- Identify your facility, yourself and your position
- Listen closely to caller's request
- Place caller on hold if you need to get someone to take the call
- Do not give information about staff or residents over the phone
- Use polite gestures such as "thank you"
- Follow facility policy for business and personal phone calls

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What are some special circumstances that can affect communication?

- Hearing impairment or loss
- Vision impairment or loss
- Stroke or TIA
- Combativeness
- Anger
- Inappropriate behavior

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Documentation

- Involves observation, reporting and documentation
- Keeping accurate records of all care given to patient while in facility or hospital

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Types of Documentation

- Admission
- History/physical exam
- Care plans
- Doctor's orders
- Doctor's progress notes
- Nursing assessments
- Nurse's notes
- Flow sheets
- Graphic record
- Intake/output record
- Consent forms
- Lab/test results
- Surgery reports
- Advance directives

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What do I need to know about charting?

- Purpose: to record patient care and prove accountability for care given
- Tips:
  - Check for right patient, room, form and chart
  - Fill out completely
  - Correct color of ink, usually blue or black
  - Correct sequence of events
  - Correct spelling
  - Correct entries (brief) facts, not opinions
  - Do not:
- Use “ditto” marks
- Use term *patient*
- Use white out for corrections

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Am I on military time?

- In health care, facilities use 24-hour clocks to reduce confusion in am/pm hours
- To change hours:
  - From 12 to 24 hour: Add 12 to the original hour

    3 + 12 = 15 = 1500 hours
  - From 24 to 12 hour: Subtract 12 from the military time

    15 – 12 = 3 = 3:00
- Hours from 12:00 am to 12:00 pm are written as 00:01-1200

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Incident Reports

- A way to document an accident or unexpected event that happens during care given

  -Examples of incidents:
  - Feeding a patient from the wrong tray
  - Fall or injury to the patient
  - Accusation against a staff member by a family
- There are state and federal guidelines to follow about filling out incident reports

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