Communication and Charting: Critical Components of Caring

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Objectives

• Discuss the concept of communication as related to health care

• Identify effective communication skills

• Describe verbal and nonverbal communication strategies

• Discuss charting as one component of communication in the delivery of care
Communication: a process by which information is exchanged between individuals through a common system of symbols, signs, or behavior. (Source: Merriam Webster on line Dictionary)
Goal of Communication: to successfully exchange thoughts and information to others, with the invitation to respond as appropriate, or required.
Components of the Communication Process

The components of the communication process are sender, recipient(s), message and feedback.
Communication occurs when one person sends a message and another person(s) receives it and responds.
What Can Interfere With The Components Of The Communication Process?

Perceptions, nonverbal cues, impaired verbal communication, listening, cultural differences.
Perception

Perception is the conscious recognition and interpretation of sensory stimuli that serve as a basis for understanding, learning, and knowing…(Source: Mosby’s Medical Dictionary 8th Ed. 2009)
Lady/Girl
Couple
Tables
How one perceives one’s “world” impacts the communication process
Impaired verbal communication

Residents may experience a decreased or absent ability to use or understand communication cues in human interaction.
Factors Include:

Hearing loss; aphasia (inability to process symbolic materials as speech, hearing, and written communication); hesitancy; reduction in fluency and rate of speech; Parkinson’s disease; and cognitive impairments.
Communication Interventions for Impaired Verbal Communication

• Speak slowly, directly and clearly to residents
• Describe carefully the care you are going to give
• Be sensitive to the resident’s facial expressions and gestures
• Speak in a manner that maintains resident’s dignity
• Provide alternative means of interactions
• Ask specific questions that require only a yes or no answer, as a nod of the head
• Use nonverbal techniques yourself as care giver
• Include resident in care even though there is no response
Nonverbal Communication

A kind of communication that uses the cues of facial expression, body gestures and voice intonation.
Examples of nonverbal cues:

• Eye to eye contact varies with cultures; however, in western cultures, we look less at people who make us uncomfortable
• Intonation of voice tends to change with differing emotions
• Leaving residents’ rooms while they are still talking
• Frowns versus smiles
What Is The Importance Of Nonverbal Communication?

The truth is, according to experts, get the body language right and you’ve mastered a very basic communication skill. Individuals stereotype their conversation partner in terms of presentation, tone of voice and body language, representing up to 93% of what is received.
Listening

Listening is making an effort to hear something; to pay attention.

Some Thoughts About Listening

• It is an acquired skill
• When we listen, we risk needing to change or being changed by what we hear
• Listening to another person’s experience does not have to mean that you agree or disagree
• Individuals who appear to be physically listening may have an emotional deafness
• They may not hear a word that is said because they’re overwhelmed, upset or nervous.

• Message senders must learn to assess or validate the receiver’s understanding of the conversation or interaction.
Cultural Competence

The term used when one gives authentic consideration to the issues present when there are ethnic, linguistic, educational and ability differences
Cultural Communication Interventions

• Determine resident’s level of fluency in English
• Pay attention to nonverbal cues from resident
• Learn the resident’s cultural values and preferences
• Avoid jargon and slang
• Use an interpreter if necessary
It’s in everyone of us
Professional Communication Boundaries
The limits that set guidelines for the interactions between the health care giver and the residents.
An inequity exists between the health care giver and the residents. This power differential arises because the care giver has knowledge, experience and authority and the residents may be vulnerable.
Examples of boundary violations are disclosure of personal information of one resident to another resident or to others who do not have a right to know, and venting personal feelings about the organization/management to residents.
The most egregious communication boundary violation is verbal abuse.

Management and health care workers are responsible for maintaining communication boundaries.
Documentation
A process by which information is exchanged between individuals through a common system of symbols, signs, or behavior.
(Source: Merriam-Webster on line Dictionary)
Communicating health care information is an important aspect of providing care to residents
Purposes of Documentation

• Serves as a means of communication among health care providers
• Fulfills professional and regulatory requirements
• Legal validation of care
• Provides a basis for education
• Facilities evaluation of strategies to promote health and safety of residents
• May be used for financial billing
Documentation is confirmation that some fact or statement is true. Anything written is relied upon as a record or proof of care rendered.
Each Long Term Care Facility selects a method for documenting care. Even though documentation isn’t done as often, it can be extensive because the facilities are highly regulated by state and federal agencies.
Forms
A care giver’s best friend. Forms, when used properly, can save time, identify areas for improvement, plan and deliver efficient care, and avoid legal pitfalls.
Confidentiality

• The health care giver has an ethical obligation to maintain resident’s confidentiality. The ethical principles involved in confidentiality are beneficence, justice, and fidelity

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Privacy of Person Health Information (PHI) of Residents

• Regulated by the Health Insurance Portability and Accountability (HIPAA) Privacy Rule

• Purpose is to define and limit the circumstances in which PHI may be used or disclosed by the facility
• Monitored by the US Dept. of Health and Human Services, Office for Civil Rights
• Health care workers may be held personally liable for invasion of privacy
• Electronic charting has specific advantages, disadvantages and some inherent legal risks
Charts

• A chart is a permanent legal document.
• The chart provides verification of the care the resident received.
• Anything written is relied upon as a record of proof of care rendered.
• The most credible evidence in various legal proceedings
• Health care providers are legally and ethically obligated to keep information confidential
Charting, In And Of Itself, May Not Be Sufficient In Communication

Some information regarding a resident may need to be reported.
Charting Should:

• Contain accurate and legible information
• Be comprehensive
• Track residents’ outcomes
• Maintain continuity of information
• Reflect nursing standards of care within the facility
• Be free of personal opinions, judgments
• Contain only abbreviations approved by the facility
Charting Guidelines*

When to Chart:

• Record nursing actions and residents’ responses after they occur
• Document medications or treatments after they are given, never before
Charting Guidelines

What to Chart:

- Symptoms or untoward behaviors of the resident
- Your observations as the caregiver
- All injuries
- All unusual health occurrences
- All contacts with the physician or other primary health care provider
• The outcome of the contact
• Untoward responses to medication or treatments
• New symptoms or behaviors as abrasions, areas of redness, refusal of meal, etc.
• Routine, ongoing plan of care for the resident
• Do not chart actions completed by others, except in instances where it is approved by administration. The notation should identify the person who actually performed the action.
Charting Guidelines
How to Chart

• Date and time of each entry
• Document both the entry time and the time the nursing action or activity took place
• Print legibly in permanent black ink or enter data electronically
• Do not leave blank lines between entries. Draw a line through unused spaces before and after signature.
• Use only approved symbols and abbreviations
• Avoid use of slang
• Entries must be clear and specific
• Entries must be free of personal opinion or value judgments
• All entries should be signed according to the record of signatures maintained by the facility
How to Chart Correcting Errors

- Draw one straight line through the incorrect entry
- Write “error” above it
- Initial and date the correction
- Never obliterate the initial entry in the resident’s record by use of white-out, eraser or other means.
How to Chart Late Entries

• Begin the documentation with “Late entry.”
• State the date and time the entry is made AND the date and time the care or observations actually occurred
• Complete the entries with signature
Legal Red Flags in Charting

- Illegible entries
- Blank lines
- Alteration of notes
- Back dating records
- Correcting errors incorrectly
- Insertion of information between lines
- Documenting for another
- Expression of opinions or judgments
• Charting inconsistencies such as lapsed time in the entries
• Failure to document communication with other health care givers
• Reference to an incident report
*Charting Guidelines*

**Sources**

- **Nursing Document**
  www.ddon.sc.gov/NR/rdonlyres/CB078DF5-506A-4514-9666-4B
  Accessed October 11, 2009

- **Ladies and gentleman of the jury, I present....the nursing documentation**
  http://www.nursingcenter.com/prodev/c e_article.asp?tid=622257
  Accessed October 8, 2009
Notes on Documentation

Be cognizant that documentation can stand alone without benefit of other communication resources.
Facilities should maintain a current list of the initials and signatures of employees who have access to residents’ records.
Examples Of Abbreviations Used:

“Output 1000cc PWFOTF”

“Resident may ambulate TTEOTH”
Incident Reports**

General definition of an incident: Any event that affects the resident or the safety of the employee. Some examples are resident injury, errors in patient care and medications, equipment failure.
Purpose of Incident Reports

Incident reports can document quality of care, identify where additional staff education is needed, and record details of the event for possible legal reference.
Completing the Incident Report Process

• Report should contain date and exact time; the description of exactly what you saw, including any witnesses; factual information; your actions and any corrective action taken; signature and date.

• Follow the facility’s policy regarding disposition of the form and follow up communication to the necessary individuals.
• Not a part of the resident’s medical record
• Appropriate to incorporate patient and witness accounts of the event and state as direct quotes. May have witnesses co-sign.
• Ensure there is only one copy
• Complete quickly; memories fail
• Facts only. It is not the opportunity to identify facility problems
• Must document the facts of event in the medical record, and the patient’s condition and response to the event.
A “Just Culture” in Incident Reporting

• To promote reporting and to achieve quality of care, a “just culture” recognizes that it’s rare for only one individual to be the cause of any event, and eliminates punitive action against the employee filing the report.
• In the “just culture”, administrators look beyond the event to identify other factors that could lead to increased quality of resident care through staff education, staff distribution and equipment

A Transformational Communication Environment

• Clear, consistent and constant communication enhances the workplace
• Communication skills that enable care givers to provide competent and compassionate care to residents of differing cultures and abilities are cultivated
• Questions of staff and residents answered with veracity and integrity
• Accountable by keeping one’s word, no matter to whom it was given
• The skill of listening is practiced
• Emotionally charged situations are dealt with reflection and not reaction
• Adherence to confidentiality and privacy standards is ubiquitous
• Trust and respect are apparent in conversations or interactions
• Fidelity to facility, administration, peers and role is reflected in conversations
• Authenticity in verbal and nonverbal interactions
• The art of thanking (expressing gratitude and appreciation, with sincerity) is pervasive
Summation of Communication and Documentation

REMEMBER

The practice of GOOD communication and documentation

Is

Good Ethics

Is

Good Law
References


