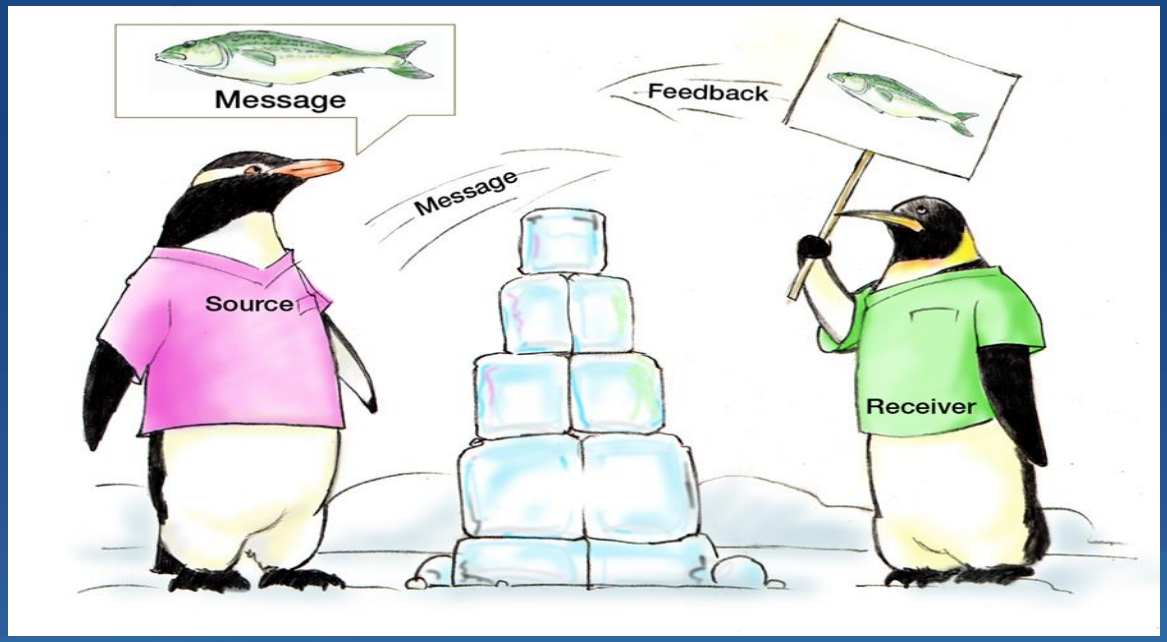
Professional Communication in Nursing

Dr. SHATHA.S.M

Definition of Communication

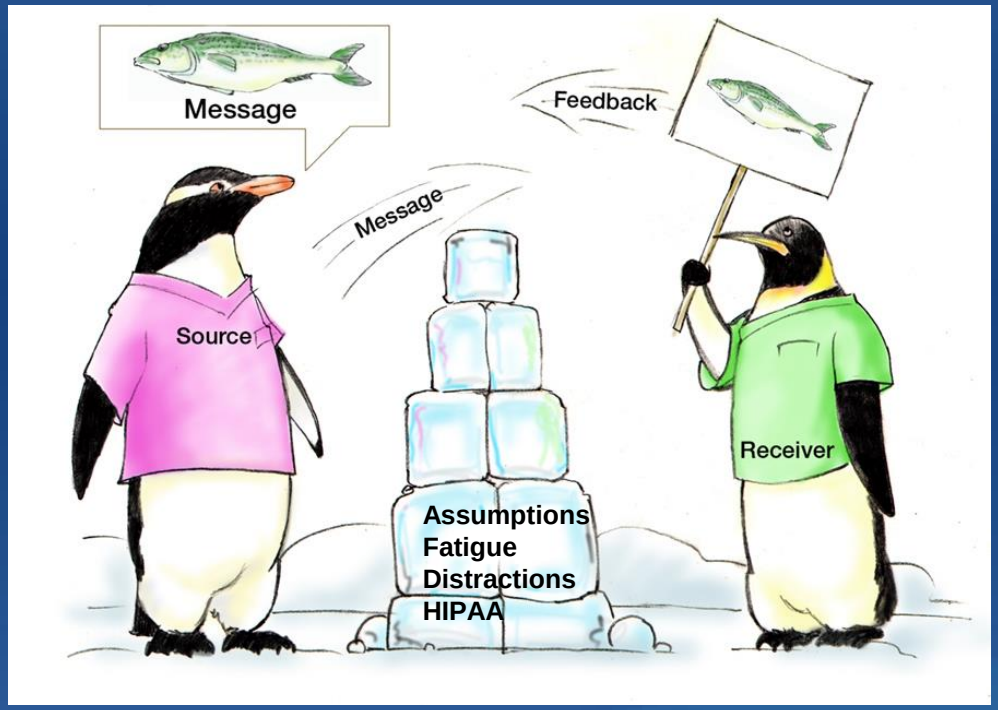
Communication is “an interaction between 2 or more persons that involves the exchange of information between a sender and a receiver” .

It involves the expression of emotions, ideas, and thoughts through verbal and non-verbal signals.



Communication is…

- The process by which information is exchanged between individuals, departments, or organizations
- The lifeline of the Core Team
- Effective when it permeates every aspect of an organization



Standards of Effective Communication

- Complete
  - Communicate all relevant information
- Clear
  - Convey information that is plainly understood
- Brief
  - Communicate the information in a concise manner
- Timely
  - Offer and request information in an appropriate timeframe
  - Validate or acknowledge information

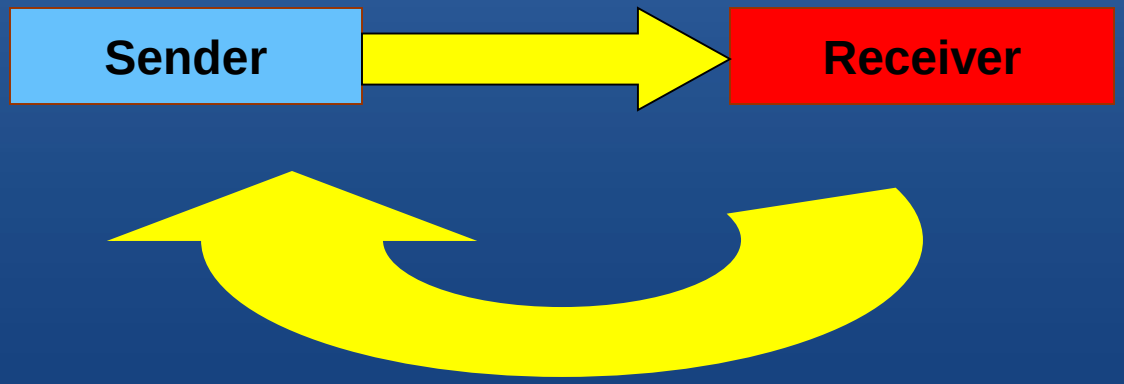
Brief

Clear

Timely

Communication is a two-way process

Message



The Communication Process

- Sender
  - Source-encoder
- Message
  - What is actually said/written, body language
  - How words are transmitted → channel
- Receiver
  - Listener → decoder → perception of intention
- Response → Feedback

Therapeutic Communication

- An application of the process of communication to promote the well-being of the client
- اريد بعد حجي هنا

Verbal Communication

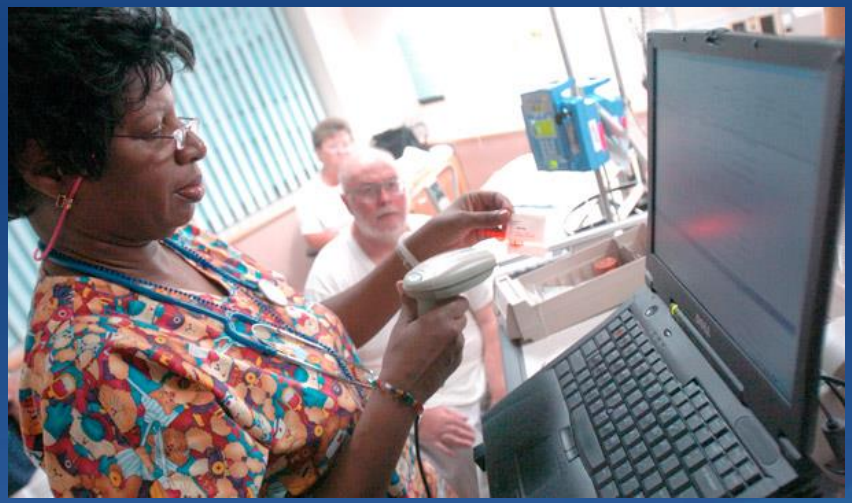
- Includes spoken and written word
- Tone
- Volume
- Cadence
- Cultural differences
- Jargon
- Slang
- Cognitive impairments
- Visual impairments
- Developmental stage

Nonverbal Communication

- All behaviors that express messages without the use of words
- Body movement
- Physical appearance
- Personal space
- Touch
- Body language
- Should be consistent with spoken word
- Cultural considerations

Electronic Communication

- Advantages
  - Fast
  - Efficient
  - Legible
  - Improves communication, continuity of care
- Disadvantages
  - Client confidentiality risk
  - HIPPA
  - Socioeconomics



Electronic Communication, *continued*

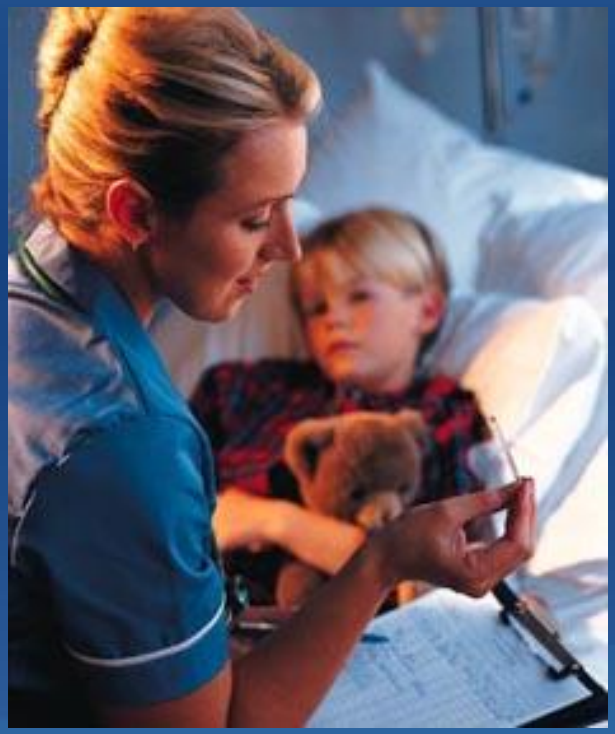
- Do not use e-mail
  - Urgent information
    - Jeopardy to client's health
  - Highly confidential information
  - Abnormal lab data
- Other guidelines
  - Agency-specific standards and guidelines
  - Part of medical record
  - Consent, identify as confidential

Factors Influence Communication Process

- Development & gender
- Sociocultural characteristics
- Values and perception
- Personal space and territoriality
- Roles and relationships
- Environment
- Congruence
- Attitudes

Development

- Language and communication skills develop through stages
- Communication techniques for children
  - Play
  - Draw, paint, sculpt
  - Storytelling, word games
  - Read books; watch movies, videos
  - Write



Gender

- Females and males communicate differently from early age
- Boys → establish independence, negotiate status
- Girls → seek confirmation, intimacy

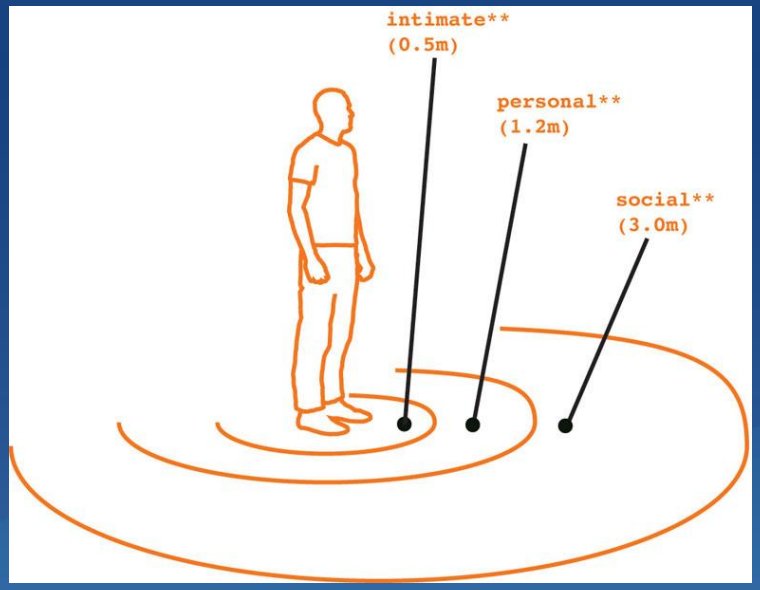
Sociocultural Characteristics

- Culture
- Education
- Economic level

- **Values and Perception**
- Values → standards that influence behavior
- Perceptions → personal view of an event
- Unique personality traits, values, experiences
- Validate

Personal Space

- Defined as distance people prefer in interactions with others
- Proxemics
  - Intimate distance →frequently used by nurses
  - Personal distance → less overwhelming
  - Social distance → increased eye contact
    - Out of reach for touch
  - Public distance



Territoriality

- Space and things
  - Individual considers as belonging to self
  - Knock before entering space
- May be visible
  - Curtains around bed unit
  - Walls of private room
  - Removing chair to use at another bed

Roles and Relationships

- Between sender and receiver
- First meeting versus developed relationship
- Informal with colleagues
- Formal with administrators
- Length of relationship

Environment

- Can facilitate effective communication
- Key factors
  - Comfort
  - Privacy

Congruence

- Congruence
  - Verbal and nonverbal aspects match
  - Seen by nurse and clients
- Incongruence
  - Sender’s true meaning in body language
- Improving nonverbal communication
  - Relax; use gestures judiciously
  - Practice; get feedback on nonverbal

Attitudes

- Interpersonal attitudes
  - Attitudes convey beliefs, thoughts, feelings
  - Caring, warmth, respect, acceptance
    - Facilitate communication
  - Condescension, lack of interest, coldness
    - Inhibit communication
  - Effective nursing communication
    - Significantly related to client satisfaction
  - Respect

Establishing the Nurse-Client Relationship

- Goal is to encourage wellness and personal growth
- Do not share intimate details
- Personal self-disclosure may be used to assist in education, building trust, and increasing self-sufficiency

Essential Skills

- Active listening
- Clarifying
- Comforting
- Focusing
- Genuineness
- Informing
- Interviewing
- Paraphrasing
- Reflecting
- Restating
- Summarizing
- Suggesting
- Therapeutic silence
- Open-ended statements and questions

Barriers to Effective Communication

- Offering your opinion
- Giving false reassurance
- Defensiveness
- Showing approval or disapproval
- Stereotyping
- “Why”

Phases

- Orientation
- Learn about the client and any concerns or needs
- Roles are defined
- Collect information
- Establish goals
- Clarify misunderstandings
- Establish rapport
- Working
- Client and nurse are ready to work toward reaching set goals
- Client anxiety is reduced by the nurse’s nonjudgmental, supportive approach
- Client is able to respond and participate in plan of care

Termination Phase

- Examine and evaluate relationship
- Review goals and results
- Say good-bye

The Anxious Client
The Angry Client
The Depressed Client

- Anxiety can be the result of many different factors
- Can interfere with communication
- Can interfere with care and treatment
- Extreme anxiety can interfere with comprehension, attention, and problem-solving skills
- Anxiety is contagious!

- Stages of Anxiety
- MILD
- MODERATE
- SEVERE
- PANIC

Interventions

- Recognize your own anxiety level
- Be aware of nonverbal cues and body language
- Decrease the environmental stimuli
- Provide brief, simple instructions
- Use active listening skills
- Assist client with effective coping mechanisms

The Angry Client

- Anger is a common underlying factor associated with violent potential
- May be related to past or current situation
- Nurse is often the target of anger because of frequent contact with the client
- Dealing with an angry client is very stressful for the nurse and may result in failure to meet needs of other clients

Interventions

- De-escalation—a communication strategy involving the reduction of anxious and/or agitated behaviors exhibited verbally or nonverbally by a client; using a calm yet firm approach to diffuse the client's state, minimizing potentially violent outbursts
- Maintain an open exit
- Use slow and deliberate gestures
- Decrease environmental stimuli
- Set limits to provide structure
- Maintain personal space
- Maintain nonthreatening position with body stance

The Depressed Client

- Depression—a common condition that affects a person's ability to function in day-to-day activities
- Symptoms include apathy, sadness, fatigue, guilt, poor concentration, sleep disturbances, and suicidal thoughts
- Subjective and objective behaviors
- Low self-esteem

Interventions

- Accept client as they are
- Be honest and empathic
- Use appropriate nonverbal behaviors
- Use open-ended questions
- Reward decision making and independent actions
- Provide comfort measures

Effective Written Communication

- Does not convey nonverbal cues
- Same as verbal AND
- Appropriate language and terminology
- Correct grammar, spelling, punctuation
- Logical organization
- Appropriate use and citation of resources

Barriers to Communication

- Stereotyping
- Agreeing and disagreeing
- Being defensive
- Challenging
- Probing
- Testing
- Rejecting
- Changing topics
- Unwarranted reassurance
- Passing judgment
- Giving common advice

Therapeutic Communication

- Interactive process between nurse, client
- Helps client overcome temporary stress
  - To get along with other people
  - Adjust to the unalterable
  - Overcome psychological blocks
- Established with purpose of helping client
- Nurse responds to content
  - Verbal, nonverbal

Therapeutic Communication Techniques

- Empathizing
  - Empathy is process
    - People feel with one another
    - Embrace attitude of person who is speaking
    - Grasp idea that what client has to say important
  - NOT synonymous with sympathy
  - Interprets clients feelings without inserting own

Empathy

- Empathy
  - Four phases of therapeutic empathizing
    - Identification
    - Incorporation
    - Reverberation
    - Detachment
  - On guard against over-distancing or burnout

Listening

- Attentive listening
  - Mindful listening
  - Paying attention to verbal, nonverbal
  - Noting congruence
  - Absorbing content and feeling
  - Listening for key themes
  - Be aware of own biases
  - Highly developed skill

Blocks to Attentive Listening

- Rehearsing
- Being concerned with oneself
- Assuming
- Judging
- Identifying
- Getting off track
- Filtering

Attending

- Physical attending
  - Face the person squarely
  - Adopt an open posture
  - Lean toward the person
  - Maintain good eye contact
  - Try to be relatively relaxed

Silence

- Using silence
  - Encouraging the client to communicate
  - Allowing client time to ponder what has been said
  - Allow client time to collect thoughts
  - Allow client time to consider alternatives
  - Look interested
  - Uncomfortable silence should be broken
    - Analyzed

Reflection

- Reflecting
  - Repeating the client's message
    - Verbal or nonverbal
  - Reflecting content repeats client's statement
    - May be misused, overused
    - Use judiciously
  - Reflecting feelings
    - Verbalizing implied feelings in client's comment
  - Encourages client to clarify

Just the Facts

- Imparting information
  - Supplying additional data
  - Not constructive to withhold useful information
  - Line between information and advice
  - Avoid personal, social information
  - Client participation in decision making → positive mental health outcomes
    - Take in and understand information
    - Educated empowered client

Deflection

- Avoiding self-disclosure
  - Deflect a request for self-disclosure
    - Honesty
    - Benign curiosity
    - Refocusing
    - Interpretation
    - Clarification
    - Feedback and limit setting
  - Assess and evaluate responses

Clarification

- Clarifying
  - Attempt to understand client's statement
  - Ask client to give an example
- Paraphrasing
  - Nurse assimilates or restates in own words
  - Fives nurse opportunity to test understanding
- Checking perceptions
  - Sharing how one person perceives another

Question and Define

- Questioning
  - Very direct way of speaking with clients
  - Open-ended questions focuses the topic
  - Close question limits choice of responses
  - Careful not to ask questions that steer answer
- Structuring
  - Attempt to create order, establish guidelines
  - Define parameters of nurse-client relationship

Pinpoint and Link

- Pinpointing
  - Calls attention to certain kinds of statements
    - Relationships
  - Point to inconsistencies
  - Similarities, differences
- Linking
  - Nurse responds to client
    - Ties together two events, experiences, feelings
    - Connect past experiences with current behaviors

Giving Feedback

- Nurse share reaction to what client said
- Give in a way that does not threaten client
- Risk of client experiencing feedback
  - Personal rejection
- Nurses should be open, receptive to cues

Focus Feedback

- On behavior, observations, description
- On more-or-less, rather than either/or
- On here-and-now: what is said, not why
- Sharing of information, ideas
- Exploration of alternatives
- Value to client
- Amount of information client able to use
- Appropriate time and place

Confronting

- Deliberate invitation to examine some aspect of personal behavior that indicates discrepancy between actions and words
- Informational confrontation
  - Describes visible behavior
- Interpretive confrontation
  - Draws inferences about the meaning of behavior

Six Skills in Confronting

- Use of personal statements
- Use of relationship statements
- Use of behavior descriptions
- Use of description of personal feelings
- Use of responses aimed at understanding
- Use of constructive feedback skills

Summarize and Process

- Summarizing
  - Highlighting the main ideas expressed
  - Conveys understanding
  - Reviews main themes of conversation
  - Use at different times during interaction
  - Don’t rush to summarize
- Processing
  - Direct attention to interpersonal dynamics

Therapeutic Communication Mistakes

- Common mistakes
  - Giving advice
  - Minimizing or discounting feelings
  - Deflecting
  - Interrogating
  - Sparring

Barriers to Communication

- Failure to listen
- Improperly decoding intended message
- Placing the nurse’s needs above client’s

The Therapeutic Relationship

- Growth-facilitating process
  - Help client manage problems in living
    - More effectively
    - Develop unused, underused opportunities fully
  - Help client become better at helping self
- May develop over weeks or within minutes
- Influenced by nurse and client
  - Personal and professional characteristics

Relationship Characteristics

- Characteristics of therapeutic relationship
  - Intellectual and emotional bond
    - Focused on client
  - Respects client as individual
  - Respects client confidentiality
  - Focuses on client’s well-being
  - Based on mutual trust, respect, acceptance

Therapeutic Relationship Phases

- Preinteraction
- Introductory
- Working: stage 1 and stage 2
- Termination

Introductory Phase

- Preinteraction phase
- Introductory phase
  - Orientation, pretherapeutic phase
  - Nurse and client observe each other
  - Open relationship
  - Clarify problem
  - Structure and formulate contract
  - Client may display resistive behaviors

Introductory Phase, *continued*

- By end of this phase client begins to
  - Develop trust in nurse
  - View nurse as honest, open, concerned
  - Believe nurse will try to understand, respect
  - Believe nurse will respect client confidentiality
  - Feel comfortable talking about feelings
  - Understand purpose of relationship, roles
  - Feel an active participant in plan

Working Phase Stages

- Stage One
  - Exploring and understanding thoughts and feelings
  - Empathetic listening and responding
  - Respect, genuineness
  - Concreteness
  - Reflecting, paraphrasing, clarifying, confronting
  - Intensity of interaction increases

Working Phase Stages, *continued*

- Stage two
  - Facilitate and take action
  - Collaborate
  - Make decisions
  - Provide support
  - Offer options

Termination Phase

- Difficult, ambivalent
- Summarizing
- Termination discussions
- Allow time for client adjustment to independence

Developing the Therapeutic Relationship

- Set mutual goals with client
- Discuss outcomes
- Many ways of helping do not require training

Skills for the Therapeutic Relationship

- Listen actively
- Help identify the client's feelings
- Be empathetic, honest, genuine, and credible
- Use ingenuity
- Be aware of cultural differences
- Maintain confidentiality
- Know your role and your limitations

Communication Techniques Working with Children and Families

- Accepting
- Broad openings
- Clarifying
- Focusing
- Observations
- Reflection
- Summarizing
- Active listening
- Collaborating
- Exploring
- Giving recognition
- Offering self
- Restatement or paraphrasing
- Validating perceptions

Developmental Considerations

- Establish rapport with children
  - Sit or lower self to child's eye level
  - Note what child is playing with or reading
  - If appropriate, agree with child/share feelings
  - Compliment a physical features, activity
  - Use calm tone of voice, appropriate language
  - Pace discussion, procedure in nonhurried manner
  - Preschoolers have limited concept of time

Establish Trust

- Establishing rapport
  - Include adolescent in discussion
  - Listen more than you talk
  - Avoid distractions
  - Be truthful with the child
- Establishing trust
  - Follow through with promises
  - Respect confidentiality
  - Be truthful, even if it isn’t what they want

Conclusion

- Nurse’s role requires communication skills
- Effective communication large role
  - Ability to deliver highest quality of care
- Nurse needs to be understood
- Nurse needs to understand messages
- Strong verbal, written communication skills
- Monitor own nonverbal communication

Documentation

- Effective communication vital to care
  - Discussion
  - Report
  - Record
    - Recording
    - Charting
    - Documenting
    - Legal document

Ethical and Legal Considerations

- American Nurses Association code of ethics
  - Access to client's record restricted
  - HIPAA regulations
  - Students bound by strict ethical code
- Ensure confidentiality of computer records
  - Personal password
  - Never leave terminal unattended logged on
  - Know policies of facility

Purposes of Client Records

- Communication
- Planning care
- Auditing health agencies
- Research
- Education
- Reimbursement
- Legal documentation
- Health care analysis

Documentation Systems

- Source-oriented record
- Problem-oriented medical record
- Problems, interventions, evaluation (PIE)
- Focus charting
- Charting by exception
- Computerized documentation
- Case management

Source-Oriented Record

- Notations for each discipline in separate sections of chart
- Narrative charting
  - Being replaced or augmented
  - Organize information in clear, coherent manner
- Convenient
- Scattered

Figure 36-8 An example of narrative notes.

NURSING NOTES

Date	Time	
6/6/09	1400	Passive ROM exercises provided for R arm and leg. ———
		Active assistive exercises to L arm and leg. Has scratch —
		marks on L and R forearms. States, My skin on my back —
		and arms has been itchy for a week. Rash not evident. —
		No previous history of pruritus. Is allergic to elastoplast
		but has not been in contact. Dr. J. Wong notified. ———
		——— T. Ritchie, RN
	1430	Applied calamine lotion to back and arms. Incontinent
		of urine. Is restless. ——— T. Ritchie, RN

Components of Source-Oriented Record

- Admission sheet
- Graphic record
- MAR
- Nurses notes
- Progress notes
- Diagnostic reports
- Physician’s order sheet
- Referral summary
- Initial nursing assessment
- Daily care record
- Special flow sheet
- Medical H&P
- Consultation records
- Discharge plan

Problem-Oriented Record

- Problem-oriented medical record (POMR)
  - Arranged according to client problems
  - Advantages
    - Encourages collaboration
    - Problem list alerts caregivers to client's needs
  - Disadvantages
    - Caregivers differ in ability to use format
    - Vigilance to maintain up-to-date problem list
    - Inefficient

POMR Components

- Database
- Problem list
  - Derived from database
  - Listed in order identified
  - Updated
- Plan of care
- Progress notes
  - Same sheet for all notes

POMR Progress Notes

- SOAP format frequently used
  - **S**ubjective
  - **O**bjective
  - **A**ssessment
  - **P**lan
- SOAPIER
  - **I**nterventions
  - **E**valuation
  - **R**evision

PIE System

- Groups information
  - **P**roblems
  - **I**nterventions
  - **E**valuation of nursing care
- Flow sheets, incorporates ongoing care plan
- Assessment establishes, records problem
- NANDA Dx or develop problem statement

Focus Charting

- Three columns usually used
  - Date and time
  - Focus: condition, nursing diagnosis, behavior, sign/symptom
  - Progress note
    - Data
    - Action
    - Response
- Holistic perspective

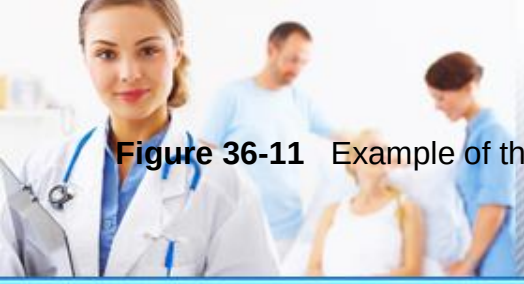


Figure 36-11 Example of the focus charting system.

Date/Hour	Focus	Progress Notes
2/11/09 0900	Pain	**D:** Guarding abdominal incision. Facial grimacing. Rates pain at 8 on scale of 0–10.
		A: Administered morphine sulfate 4 mg IV.
0930		**R:** Rates pain at 1. States willing to ambulate.

Charting by Exception

- Charting by exception (CBE)
  - Flow sheets
  - Standards of nursing care
  - Bedside access to chart forms
- Advantages
  - Elimination of lengthy, repetitive notes
  - Presumption that nurse did assess client

Computerized Documentation

- Manage huge volume of information
- Information easily retrieved, format variety
- Can generate work list for shift
- Relatively easy
  - Standardized lists, add narrative information
  - Speech recognition technology
- Transmit information between settings
  - MDS

Computerized Documentation Pros

- Facilitates focus on client outcome
- Fast, efficient use of time
- Legible
- Link various sources, links to monitors
- Bedside terminals
  - Synthesize information
  - Eliminate need for notes
  - Permit immediate order checking

Computerized Documentation Cons

- Client privacy concerns
- Breakdowns make information unavailable
- System expensive
- Extended training periods

Case Management

- Emphasizes quality, cost-effective care
- Multidisciplinary approach
  - Planning and documenting client care
- Critical pathway
- Incorporated graphics and flow sheets
- Goal not met is variance
  - Unexpected outcome
  - Document unexpected event

Figure 36-16 Excerpt from a critical pathway documentation form.

CRITICAL PATHWAY: TOTAL HIP REPLACEMENT

	DOS/Day 1	Days 2–3
Pain Management	Outcome: • Verbalizes comfort or tolerance of pain Circle: V NV Variance:	Outcome: • Verbalizes comfort with pain control measures Circle: V NV Variance:
Respiratory	Outcomes: • Breath sounds clear to auscultation • Achieves 50% of volume goal on incentive spirometer Circle: V NV Variance:	Outcomes: • Breath sounds clear to auscultation • Achieves 100% of volume goal on incentive spirometer Circle: V NV Variance:
Key: V = Variance NV = No Variance		
Signature:	Initials:	
Signature:	Initials:	

Figure 36-17

Example of Critical Pathway.

A client has had a below-the-knee amputation. On the third postoperative day he has a temperature of 38.8°C (102°F). Lung sounds are clear and he is not coughing. The nurse notices redness and skin breakdown over the client's sacrum. The critical pathway outcomes specified for Day 3 are "Oral temperature 37.7°C (100°F)" and "Skin intact over bony prominences." The nurse should chart the following variances:

Date/Time	Variance	Cause	Action Taken/Plans
4/16/09 0900	Elevated temperature (102°F)	Possible sepsis	4/16—Blood cultures x 3 per order. Monitor temp. q1h. Monitor I&O, hydration, and mental status.
4/16/09 1130	Impaired skin integrity: Stage 1 redness, 2-inch circular area on sacrum	Client does not move about in bed unless reminded	4/16—Positioned on L side. Turn side-to-side q2h while awake. On every client contact, remind client to move about in bed. Apply Duoderm after bath.

Case Management, *continued*

- Advantages
  - Promotes collaboration
  - Helps to decrease length of stay
  - Efficient use of time
  - Goal-focused
- Disadvantages
  - Best for clients with one or two diagnoses

Documenting Nursing Activities

- Admission nursing assessment
- Nursing care plans
- Kardexes
- Flow sheet
- Progress notes
- Nursing discharge/referral summaries

Admission Nursing Assessment

- Can be organized by health patterns
- Body systems
- Functional abilities
- Health problems and risks
- Nursing model
- Type of health care setting

Nursing Care Plans

- JC requires clinical record include
  - Evidence of client assessments
  - Nursing diagnoses and/or client needs
  - Nursing interventions
  - Client outcomes
  - Evidence of a current nursing care plan
- Traditional care plan written for each client
- Standardized care plans save time

Kardexes

- Concise method for organizing, recording
- May/may not be part of permanent record
- May be in pencil
- May be organized into sections
  - Pertinent information, allergies
  - Medications, IV fluids
  - List of treatments, procedures
  - Procedures orders

Kardexes, *continued*

- Specific data on how physical needs to be met
  - Diet, assistance needed with feeding
  - Elimination devices
  - Activity
  - Hygienic needs, safety precautions
- Problem list with stated goals, nursing approaches
- Quick visual guide

Flow Sheet & Progress Notes

- Flow sheet
  - Record data quickly, concisely
  - Graphic record
  - Input and output (I & O)
  - Medication administration record (MAR)
  - Skin assessment record
- Progress notes
  - Progress, interventions, re/assessment data

Nursing Discharge

- Completion on discharge/transfer
  - If given to client, family → understandable terms
- Transferred within facility, to/from long-term care facility
  - Report goes with client for continuity of care
- Usually includes:
  - Client's status description, resolved problems

Referral Summaries

- Usually include:
  - Unresolved continuing health problems
  - Treatments to be continued
  - Current medications
  - Restrictions related to activity, diet, bathing
  - Activities of daily living (ADL) abilities
  - Comfort level
  - Support networks

Referral Summaries, *continued*

- Client education provided in relation to
  - Disease process
  - Activities and exercise, special diet
  - Medications
  - Specialized care or treatment
  - Follow-up appointments
- Discharge destination and mode
- Referrals

Facility Specific Documentation

- Long-term care documentation
- Home care documentation

Long-Term Care Documentation

- Two types of care
  - Skilled or intermediate
- Requirements based on
  - Professional standards
  - Federal, state regulations
    - HCFA
    - OBRA law
    - Medicare and Medicaid requirements

Long-Term Care Documentation, *continued*

- Nurse completes nursing care summary
  - Once a week for skilled-care clients
  - Every 2 weeks for intermediate care
  - Summary addresses:
    - Specific problems noted in care plan
    - Mental status
    - ADLs, hydration, nutrition status
    - Safety measures needed
    - Medications, treatments
    - Behavior modification assessments

Long-Term Care Documentation, *continued*

- MDS and plan of care within time specified
- Keep record of visits, family phone calls
- Requirements
- Review, revise care plan every 3 months
  - When client's health status changes
- Document and report any systems change
  - Primary care provider, client's family
  - Document interventions, progress

Home Care Documentation

- Health Care Financing Administration (HCFA) mandated
  - Standardized
  - Medicare and Medicaid
- Two records required
  - Home health certification/plan of treatment form
  - Medical update and client information form
- Nurse completes forms

Home Care Forms

- Comprehensive nursing assessment
- Plan of care
- Progress note at each visit
  - Note changes
  - Interventions
  - Client responses
  - Vital signs as indicated
- Monthly progress nursing summary

Home Care Forms, *continued*

- Copy of care plan in client's home
- Report changes of plan of care to MD
  - Document that changes were reported
- Encourage client, caregiver to record data
- Write discharge summary for physician
  - Notify reimbursers services discontinued

General Guidelines for Recording

- Date and time
- Timing
  - NO recording prior to providing care
- Legibility
- Permanence
- Accepted terminology
  - Approved by agency
  - Joint Commission DO NOT USE LIST

General Guidelines for Recording, *continued*

- Correct spelling
- Signature
  - Follow agency policy
- Accuracy
  - Client's name, identifying information
  - Observations and facts
  - Recording a mistake
    - Draw line through it and write "mistaken entry"
    - Name or initials

Figure 36-19 Correcting a charting error.

Date	Time	Progress Notes
9/12/2009	0800	~~Breath sounds diminished throughout all lung fields. C/O "shortness of breath".~~ N. Smith, RN.
9/12/2009	0805	Mistaken entry above, wrong client ----------N. Smith, RN.

General Guidelines for Recording, *continued*

- Sequence
- Appropriateness
- Completeness
  - Reflect nursing process
  - Omitted care must also be recorded
    - What, why, who
- Conciseness

Legal Prudence

- Legal protection to nurse, caregivers, facility
  - And client
- Admissible in court as legal document
- Adhere to professional standards
- Follow agency policy and procedures

Do's and Don'ts

- Do
  - Chart changes
  - Show follow-up
  - Read prior notes
  - Be timely
  - Objective, factual
  - Correct errors
  - Chart teaching
  - Quotes
  - Responses
- Don't
  - Leave blank spaces
  - Chart in advance
  - Use vague terms
  - Chart for others
  - Use "patient" or "client"
  - Alter record
  - Record assumptions