

Communication Within the Healthcare Arena
Staff Communication, Admission, Discharge, and Transfer

- Communication in Healthcare System
 - Client care requires effective communication between all members of the care team
 - Good communication
 - Helps to prevent errors
 - Promotes patient safety and high-quality care
 - Increases patient satisfaction
- Characteristics of Effective Communication
 - Accurate
 - Correct information
 - Concise
 - Say everything, but don't embellish
 - Thorough
 - Include all pertinent information
 - Objective
- Verbal Communication
 - Reporting Patient Data
 - Discussions allowing a review of information to identify problems and recommend solutions
 - Communicating specific information
 - Be concise
 - Bedside shift report
 - Telephone report
 - Collaborative rounds
 - PerfectServe Care Team
 - Web-based phone tools
- Bedside Shift Report
 - Change of shift report: Gives a report about each patient to shift coming on
 - Major purpose is to communicate & provide continuity of care from one shift to the next
 - By giving a summary of pt. needs & details of care needed
 - Face to face in patient rooms
 - Allows for feedback and patient participation
 - Give without idle chatter, gossip, confidentially
 - Concise, pertinent information.
- Telephone Report
 - Always write down and read back information to the MD or the caller i.e. lab results
 - COURTEOUS use manners
 - Write down & read back message to caller
 - *Cannot take orders from doctor as a student*
 - Legal Guidelines:
 - Record message as soon as possible
 - Date & time of phone call
 - Verbatim order
 - "V.T.O. with read-back" - followed by Doctor's name

- Sign your name
- Written Report
 - Documentation
 - Anything written or printed that is relied on as a record of proof for authorized persons (patient)
 - Written Communication includes reports & records
 - Reports:
 - Verbal, Written, or Computer-based exchange of information to others.
 - Written recording of patient info becomes part of a legal document called the patient chart or record.
- Communication in Healthcare: Records
 - Records
 - Always written communication
 - Permanently documents information relevant to patient's healthcare record
 - Legal document
 - Business record for the organization
 - Effective documentation reflects
 - Quality of care
 - Provides evidence of each healthcare team member's accountability in giving care
 - Purpose of Records
 - Communication
 - Financial billing
 - Education
 - Assessment
 - Research
 - Auditing
 - Legal documentation
 - Historical documentation
 - Care planning
 - Reflects relationship between documentation & healthcare reimbursement
- Legal Guidelines for Charting
 - Chart is a legal record
 - Accurate, concise, thorough, & objective
 - Confidential
 - Legibility & black ink only for handwritten charts
 - SLIDE Rule (single line, initial, date, error)
 - Military Time
 - Document late entries with date and time
 - Correct chart & correct spelling
 - Chart patient's words in quotes
 - Approved abbreviations only
 - Chart after completion & never for anyone else
 - Care not charted is care not done!

- Common charting problems
 - Incorrect time charted
 - Failing to chart verbal orders or having verbal orders signed
 - Write down and read back!
 - Charting in advance
 - Incorrect data charted

- Principles of Proper Recording:
 - Charting must be
 - Factual
 - Accurate
 - Complete but Concise
 - Current
 - Organized

 - Whether hand-written or EMR, all nursing documentation should contain
 - Assessment
 - Intervention
 - Client response or changes
 - Accurate account of events
 - Objective descriptions
 - Recorded in a timely manner

 - Never Chart:
 - Labels to describe patient's behavior
 - Don't refer to staffing issues
 - Incident reports
 - Explaining a mistake
 - Airing your complaints
 - Charting informed when only mentioned it
 - Never refer to another patient by name or patient

 - Documentation Formats
 - Source Oriented Record
 - Problem Oriented
 - SOAP Notes
 - PIE Notes
 - Other:
 - focus charting
 - list charting
 - Computerized

 - Source Oriented Record
 - Source of the charting department-PT, RT, Radiology, Nursing, Lab
 - Narrative charting- written notes containing care, findings etc. - nurses notes, progress notes, consults, treatments, lab reports, discharge plan....
 - Advantage
 - Easier for each discipline to locate their own records

- Disadvantage
 - Info can be scattered & difficult to find chronological order
- Problem Oriented Record
 - Organized to focus on problems, not source of info
 - Members of HCT contribute info to problem list, plan of care, & progress notes
 - Record all on the same sheets
 - Advantages
 - Encourages collaboration - Increases data gathered from all health team members
 - Emphasizes client's perception of the problem
 - Requires ongoing evaluation, continuity, & effective communication
 - Disadvantages
 - Inefficient as assessments & interventions that apply to more than one problem are repeated
 - Not easy to locate separate sections to document
- SOAP NOTE
 - S= Subjective Data-"what patient says"
 - O= Objective Data- information observed or
 - measured by one of the healthcare team
 - A= Assessment-Take both S&O information &
 - interpret or draw conclusions.
 - P= Plan- plan of care designed to resolve the problem
 - Strengths-addresses specific problems, gives guidance for info, notes organized same author to author
 - Weaknesses-difficult to use in fast paced change in condition, repetitive charting necessary.
- PIE NOTES
 - PIE Notes
 - Eliminates traditional care plan & incorporates an ongoing care plan
 - P - Problem Identification, Nursing Diagnosis Related to patient condition.
 - I - Intervention or Nursing Action taken.
 - E - Evaluation of Nursing Intervention & client's response to therapy
- Electronic Medical Record (EMR)
 - Constant availability of information across the lifespan
 - Ability to monitor quality
 - Access to stored data
 - Ability of patient to share knowledge & activities that influence the patient's health
 - Conservation of time used more efficiently –bedside terminals
 - Requests & results sent more efficiently
 - Trends noticed easier –VS, lab data etc.
 - Research ease-statistics, epidemics etc.
 - Standards of care –tighter control on documentation standards, focus on client
 - Links various data sources-MD, hospital, etc.
 - No loss of pages

- Principles of Proper Recording
 - Nurses need to write quality statements that contain an adequate quantity of information
 - Need to document all nursing actions in response to patient problems
 - Patient response or lack of response to medication, treatments, & teaching
 - Patient education & counseling activities
 - Record all changes in patient condition
 - Chart, *a minimum* of 1X per shift
 - More with patient change, or depending on practice setting
- Principles of Proper Recording
 - Factual-descriptive, objective info see, hear, feel, smell. Do not use appears, seems, etc. Be objective not interpretive. Do not use catchall statements “In good condition”
 - Accurate-exact measurements, cm, inch, accepted abbreviations, correct spelling & grammar, dated, initialed, military time
 - Complete-thorough but concise
 - Current-should be timely i.e. going to x-ray, c/o pain, dressing with bloody drainage, medication
 - Washed hair or mouth care could be charted later
 - Organized-logical order i.e. Head to toe assessment

Admission, Discharge, & Transfer Process

- Admission
 - Covers the entire period from the time the client enters the door until the time settled in
- Discharge
 - Official procedure helping clients to learn to leave the health care facility
- Transfer
 - From one room, unit, or facility to another
- Admission: Overview
 - Challenge to nursing:
 - Meet the needs of clients & families
 - Comprehensive & holistic
 - Admission increases stress
 - Nurses are the primary resource:
 - Spend more time with the patient
 - Assure continuity of care
 - Coordinate care with other interdisciplinary teams
 - Discharge process
- Patient Bill of Rights
- What are your rights?
 - You have the right to be informed about the care you will receive.
 - You have the right to get important information about your care in your preferred language.
 - You have the right to get information in a manner that meets your needs, if you have vision, speech, hearing or mental impairments.
 - You have the right to make decisions about your care.
 - You have the right to refuse care.
 - You have the right to know the names of the caregivers who treat you.
 - You have the right to safe care.
 - You have a right to have your pain addressed.

- You have the right to learn about your care in your preferred language
- Advance Directives/Living Will
 - Advance Directives:
 - Written instructions to convey wishes regarding medical treatment
 - Living Will:
 - Specifies end of life decisions when no longer able to make
 - Legalities vary from state to state
 - Healthcare POA:
 - An agent to make medical decisions if you are unable to do so
- Preliminary Admission Procedure
 - Prior to reaching the unit:
 - By order from MD
 - Admission into Acute Care:
 - Registration:
 - Basic demographic information
 - Assures correct legal identification
 - Info entered onto computer 'face sheet'
 - Informed consent
- Informed Consent
 - Diagnosis of patient, if known
 - Nature & purpose of proposed treatment
 - Risks & benefits
 - Alternatives (regardless of cost)
 - Risk & benefits of alternative treatment
 - Risks & benefits of not receiving a procedure
 - Complete description of treatment procedure
 - Description who will participate in procedure
 - Description of potential harm, pain, discomfort
 - Options for other treatment
 - Right to refuse treatment
- Patient Identification
 - Always read ID and ask client to verbally give name & DOB to compare & confirm accuracy
 - Patient Identification:
 - Assigned permanent ID #
 - Name, DOB, ID #
 - Used for all procedures and interactions
 - Must verify before placing name band on client
- Admission to Unit
 - Room Preparation
 - Gather supplies
 - Bed in lowest position unless transfer from stretcher
 - Be sure to zero bed scale before patient arrival
 - Nursing Admission
 - Greet patient, identify self
 - Establish identification
 - Provide privacy
 - Weight/height
 - Orient to call bell

- Head/Toe, admission assessment
 - Place care items within reach
- During Admission Process...
 - Make patient feel comfortable and accepted; treat each person with dignity
 - Allay fears
 - Establish good rapport
 - Routines
- Discharge and Transfer Process
 - Discharge process begins on admission
 - Planning more than completion (ongoing)
 - ALL WHO CARE FOR PATIENT SHOULD PARTICIPATE!
 - Case managers fill this role
 - Need our expertise & knowledge of patient
 - Liaisons between hospital & community
 - Ensure smooth transition
 - Home health vs. nursing home
 - Emotional stability to go home
 - Financial concerns
 - Special Needs
- Indications for Discharge & Transfer
 - Level of care has changed
 - Another setting is required
 - Facility does not offer care required
 - Patient is ready for discharge
 - Nurse's Role
- Case Management Referrals
 - Behavioral Health
 - Durable Medical Equipment (DME)
 - Walker, commode, etc.
 - Acute Rehabilitation Facility (ARC)
 - Sub-Acute Care (SNF)
 - Long-term Care (LTC)
 - Home Health Care Services (HHC)
 - Hospice/Palliative Care
- Referrals
 - Health Care Referral
 - Request for service outside scope of referring professional
 - Social worker, hospice, palliative care, home health aide, housekeeper, etc.
 - Level of discharge depends on needs:
 - Basic plan (basic self-care i.e. smoking cessation hotline)
 - Simple referral (community resource i.e. AAA)
 - Complex referral (requires case management)
- Referral for home health care
 - Use of professional, para-professional, & equipment to patients in their homes
 - Health maintenance & prevention of illness
 - Patient & family education
 - Rehabilitation

- Reimbursement through private or government insurance & JCAHO accreditation to assure quality standards
- Day of Discharge/Transfer
 - Communicate anticipated time of discharge or time of arrival to new facility
 - Complete documentation (including teaching)
 - Give verbal report to nurse at receiving facility
 - Confirm mode of transportation (private vehicle, ambulance...)
 - Make sure the patient is dressed and items packed up
 - Account for all items (medications, equipment, items sent to security etc.)
- Discharge Education
 - Patient & Family Education
 - Language
 - Includes procedures, diets, medications, referrals, extended care facilities, follow-up
 - Test knowledge
 - Return demonstration
 - Teach-back
 - Provide paperwork, manuals, charts
- Standards for Discharge Education
 - Identify safety concerns at home
 - Review signs & symptoms
 - Provide phone numbers
 - Provide community resources
 - Instructions for treatment
 - Dietary restrictions & guidelines
 - Amount & frequency of therapies
 - Medication instructions
- Discharge Documentation
 - Need MD order on chart/EMR
 - Reconcile all medications
 - With Cerner, we use patient education from EMR- select topics to educate on, print copies for discharge folder
 - Make a copy of the signed discharge paperwork for the paper chart and patient receives a copy
 - Document discontinued equipment (i.e. PIV)
 - If transferred- document where the patient is going, with what equipment, to whom report was provided, means of transport, and time left.
 - If transferred to another facility: complete interagency form prior to transfer
- Other Discharges
 - Death
 - Death certificate
 - Expiration release form
 - Notify MD if not present
 - Notify Nurse Supervisor
 - Against Medical Advice (AMA)
 - Documentation in notes
 - MD & Supervisor aware
 - MD still writes an order!!!
 - Patient Right
- After discharge...

- o Transport notified: can assist to car when ride downstairs or taxi available
- o Break down the room - linens, trash, IV pumps/bags
- o Housekeeping notified
- o Supervisor notified
- o Paper Chart broken down and sent to medical records
- o A discharge cancels ongoing orders: meal trays from dietary, daily services etc...