Communication, Collaboration, and Documentation NCLEX Review

I. COMMUNICATION

Communication is a dynamic, purposeful, reciprocal process of sending and/or receiving a message. The need to communicate is universal because it is the way people convey and fulfill needs.

A. Concepts about communication

- All verbal communication and nonverbal communication transmit meaning.
- Communication is a learned process.
- Communication can occur within the self (intrapersonal); between two people (interpersonal); when sending a message (e.g., public speaking); or communicating within a group (e.g., self-help, and social groups, and group therapy).
- Recurring ideas and thoughts (themes) communicated during an interaction provide insight to a client's feelings.
- A trusting relationship is basic to effective communication.
- A client's degree of expression (emotional affect) reflects the client's mood.
- Humor is highly subjective; it can mean different things to different people.
- Clients have a potential for growth as a result of verbal and nonverbal communication.
- Previous patterns of communication can become inadequate when one is ill or under stress.
- Communication is confidential information and should be shared only with health team members.

B. Elements of communication

1. Sender (encoder/source): Person who conveys a message.
2. Message: Information communicated; includes language, words, voice intonation, and gestures.
3. Channel of communication (mode): Vehicle used to convey a message; includes written, oral, and touch.
4. Receiver (decoder): Person who acquires a message.
5. Feedback (response): Response from the receiver to the sender.

C. Factors affecting the communication process

1. Attitudes, values, beliefs, and experiences.
2. Culture, education, and language.
3. Developmental level.

-The very young are concrete thinkers and have little or no experience.
-Adults are more abstract thinkers.
- Older adults may have vision and hearing loss that interferes with communication.

4. Gender.

- Males and females generally communicate differently from an early age.
-Females seek intimacy and validation and reduce differences; boys use language to negotiate

status and establish independence.
- Differences are changing as gender roles become less distinct.
5. Authority one ascribes to a role (e.g., some see nurses as authority figures, whereas others see nurses as servants).
6. Ineffective perception or selective inattention: May distort a message.

D. Barriers to communication

- Unwillingness to listen to another point of view.
- Physical factors, such as an uncomfortable environment (e.g., too hot or too cold), excessive noise, or distractions.
- Adaptation to disease, such as aphasia, an impaired ability to communicate through speech, writing, or signs because of brain dysfunction (e.g., receptive or expressive aphasia); impaired ability to say words (dysarthria); impaired cognition (e.g., dementia or delirium); oral problems; fatigue; and pain.
- Treatment-related factors, such as laryngectomy, or artificial airways, such as tracheostomy or endotracheal tube.
- Psychological factors, such as lack of privacy, anxiety, and fear.

E. Phases of the communication process
1. Pre-interaction phase.
- This phase occurs before meeting the client.
- The nurse gathers information about the client.

2. Orientation phase.
- Initially, the nurse is in the stranger role.
- The nurse meets a client and begins to establish a relationship of rapport and trust.
- Introductions and initial exchange of information occurs.
- The purpose of the visit is explained, roles are clarified, and an agreement or contract about the relationship may be formulated.
- The termination phase is initiated in this phase.

3. Working phase.
- Most communication occurs during this phase.
- This phase is the active part of the relationship.
- The nurse and client work together to address client needs, feelings are shared, caring is demonstrated, and mutual respect is maintained.
- The nurse may function as caregiver, counselor, teacher, resource person, and so on.
- The nurse motivates a client by identifying progress and supporting movement toward independence.
- Anxiety may increase during this phase, as the client may need to learn new adaptive behaviors.
- Preparation for the termination phase continues.

4. Termination phase.
- Actual termination occurs at the conclusion of a relationship.
- Termination occurs at discharge, at the end of a shift, or when the goals of the relationship are achieved.
- Goals and objectives are summarized, adaptive behavior is reinforced, and additional resources available are arranged for the client.

- Some clients become emotional during this phase because they feel angry, rejected, or fearful of leaving a safe environment; the nurse needs to address these feelings.

F. Modes of communication
1. Verbal communication: Uses spoken or written words to communicate a message; characteristics include the:

- **Clarity:** Simple words and sentence structure are better understood.
- Intonation: Reflects feeling behind words; loud or soft volume, cadence, and pitch can impart a message, such as anger, excitement, sarcasm, and fear.
- **Pacing:** Speed, rhythm, and patterns of delivery can convey anxiety, indifference, and attention; pace must be fast enough to maintain interest but slow enough for receiver to decode the message.
- **Relevance:** Message needs to be conveyed when the receiver is ready and able to receive the message; information must be important to the client.

2. Nonverbal communication: Message that is sent and received without use of spoken or written words; involves use of body language; may be more accurate than verbal communication because it is less consciously controlled; characteristics include the following:

- **Facial expression:** Can convey meaning or mask emotions; some expressions are universal, such as a smile (happiness) or a frown (displeasure); can be subtle, such as raising the eyebrows.
- **Gestures:** Emphasize spoken word; some have same meaning regardless of culture, such as waving indicates hello or goodbye; different gestures may have similar meanings, such as shaking a fist versus cold, stillness when angry.
- **Eye contact:** In Western cultures, indicates interest and attention, whereas downcast eyes may indicate low self-esteem, powerlessness, and sadness; however, in some cultures, downcast eyes show respect.
- **Posture and gait:** Erect posture, head held up with a rapid gait indicates well-being and confidence; slumped, slow, shuffling gait with head held low indicates illness, depression, or impaired self-esteem; crossing legs and arms indicates a defensive posture.
- **Touch:** Generally conveys caring, concern, encouragement; some clients do not like to be touched, and touching is unacceptable in some cultures (e.g., only relatives can touch an orthodox Jewish man).
- **Territoriality and space:** People have a physical zone around the body that is culturally and individually defined.
  (1) Intimate: 0 to 18 inches; used for providing nursing care or emotional support, such as hygiene and hand holding.
  (2) Personal: 1.5 to 4 feet; used for therapeutic communication, such as nurse-client conversation, counseling, and teaching.
  (3) Social and public: 4 feet and beyond; used when performing more formal interventions, such as making rounds, teaching a class, or facilitating a group.

II. THERAPEUTIC VS. NONTHERAPEUTIC COMMUNICATION

Therapeutic communication is interaction between a nurse and a client in which the nurse focuses

on the feelings, concerns, needs, and/or objectives of the client. Nurses must develop a repertoire of verbal and nonverbal techniques that can be used to facilitate therapeutic communication as well as be aware of the various attitudes and approaches that can hinder communication. The therapeutic use of self is the most valuable tool that nurses must facilitate therapeutic communication and ultimately develop an effective nurse-client relationship.

Therapeutic Communication Techniques and Related Nursing Care

Therapeutic Communication Technique	Nursing Care
Silence • Provides time for the client to process what was said, reflect, and articulate a response. • Encourages the client to initiate or continue a conversation.	• Maintain an open posture • Maintain an unhurried manner.
Offering Self • Indicates a nurse's attention and interest without expectations.	• Maintain an open posture. • Maintain an unhurried manner. • Example: Say, "I will sit with you for a while."
Open-Ended Questions • Allows the client to control the direction of the conversation to an area of concern.	• Ask questions that require more than one-word answers and invite a more detailed response. • Example: "Tell me about how you have been managing your illness."
Direct Questions • Facilitates collection of specific information. • May interfere with exploration of feelings because they may be too blunt and threatening.	• Keep questions short and simple. • Example: "Have you received the pneumococcal (PVC) vaccine?"
Paraphrasing • Encourages further discussion by repeating content in same or similar words. • Conveys that the message was understood. • Allows the client to hear what he or she said.	• Listen attentively. • Focus on content. • Example: The client says, "When I'm discharged, I might have a hard time because I live alone." The nurse responds, "You sound concerned about how you are going to manage."
Reflection • Encourages further discussion by focusing on emotional themes and feelings. • Indicates active listening. • Helps the client to identify emotional themes and feelings.	• Listen attentively. • Focus on feelings rather than content. • Example: The client says, "I don't understand how I had a heart attack. I don't smoke or eat fatty foods, and I exercise regularly." The nurse responds, "It must be frustrating to have a heart attack when you did everything right."

Clarifying • Encourages elaboration on unclear messages. • Ensures that the message is understood as intended; minimizes misunderstanding.	• Be nonjudgmental; do not place responsibility for lack of understanding on the client. • Example: “I don’t understand what you mean when you say that your pain feels like melting lava.”
Focusing • Directs conversation to areas of concern; targets discussion to key points. • Encourages the client to expand on an idea, thought, or feeling.	• Focus on the priority topic of concern. • Example: “Earlier you mentioned that you are having a problem with recurrent diarrhea.”
Validating • Identifies and supports what the client feels or believes. • Demonstrates respect for the client. • Demonstrates empathy.	• Maintain a nonjudgmental, empathetic demeanor. • Example: “I can understand how difficult it must be to wait 5 days for a biopsy result.”
Touch • Communicates caring, concern, and encouragement.	• Use touch cautiously because some clients prefer not to be touched, touch can be misunderstood, and touch invades a person’s intimate space. • Examples: Hold a client’s hand or place an arm around a client’s shoulder.
Summarizing • Highlights important points in a conversation, such as progress made and tasks that may still need to be accomplished.	• Review just the most important points. • Provide a summary in writing when appropriate. • Example: “Let’s review what we accomplished today.”

Nontherapeutic Communication and Preventive Nursing Care

Nontherapeutic Communication	Nursing Care
Being Judgmental • Imposes the nurse’s opinions, values, beliefs, and standards on the client. • Demonstrates lack of respect for the client.	• Be aware of own values, beliefs, standards, and opinions and do not impose them on others. • Use words that demonstrate acceptance. • Maintain an empathetic demeanor.
Using Medical Jargon • Confuses clients. • Communicates that the nurse is not interested enough to make information understandable.	• Use words that can be understood; avoid use of medical jargon, such as medical terminology, acronyms, and slang. • Offer opportunities to ask questions; answer all questions to the client’s satisfaction.

• Demonstrates a demeanor of superiority and arrogance.	• Seek feedback to ensure understanding.
Using Ridicule or Sarcasm • Conveys a hostile attitude through words, tone of voice, or actions.	• Avoid cutting, caustic, sarcastic, and hostile remarks. • Avoid gestures or actions that demean the client.
Using Probing Questions • Invades privacy because it attempts to obtain information to satisfy one's curiosity. • Pressures the client to discuss topics before he or she is ready.	• Ask questions based on the client's needs, not curiosity. • Use open-ended questions.
Focusing on Self • Demonstrates lack of interest in the client. • Demonstrates an attitude of self-importance and egocentricity.	• Remember that the client is the center of the health team. • Focus on the client's needs and not self-needs.
Stereotyping • Devalues client uniqueness and individuality. • Demonstrates opinions either blatantly or subtly, such as men who cry are not manly, and clients who are health-care professionals do not need health teaching.	• Assess own beliefs, such as stereotypes, biases, and prejudices, and ensure that they do not affect professional relationships. • Accept each client as unique.
Changing the Subject • Indicates lack of interest in the client's concerns or feelings. • Reflects that the nurse feels uncomfortable talking about the topic. • Cuts off communication when the client may be ready to discuss an emotionally charged topic.	• Identify health-care topics that cause anxiety within one's self and seek education or counseling to become therapeutic in the health-care role. • Listen attentively. • Focus on the client's concerns.
Providing False Reassurance • Minimizes the client's concerns. • Violates trust.	• Answer questions truthfully; base reassurance on facts. • Address underlying concerns.
Minimizing Feelings • Devalues the validity of the client's feelings.	• Use the communication technique of reflection. • Address feelings.
Giving Advice • Bases responses on one's own values and beliefs rather than on what is important to the client. • Limits the client's right to be a partner in	• Assist the client to explore his or her own feelings, concerns, opinions, and options. • Assist the client to use critical thinking to arrive at a conclusion.

problem-solving. • Supports dependence and is controlling.	
Using Clichés, Colloquialisms, and Slang • Trivializes the client's concerns. • Causes misunderstanding.	• Use words that the client can understand. • Avoid comments that may have ambiguous meanings or multiple interpretations.
Using Terms of Endearment • Demonstrates lack of respect. • Reflects an unprofessional demeanor.	• Call the client by his or her name. • Avoid use of intimate names (e.g., honey, dear, sweetie, mom, or pop).
Responding Defensively by the Nurse • Demonstrates the nurse's attempt to protect the self rather than focus on the client's concerns; defensive responses usually are precipitated by clients who are angry, demanding, or critical. • Minimizes the client's concerns. • Focuses on content rather than feelings.	• Identify the underlying cause of the client's behavior; clients' angry, demanding, or critical responses are attempts to protect the self; all behavior has meaning. • Focus on the client's feelings. • Involve the client in identifying a resolution, such as, "I am sorry that I did not meet your expectations. What can I do now to help you?"
Challenging the Client • Requires the client to defend his or her feelings or point of view. • Ignores the client's feelings and rights. • Causes the client to abandon a coping mechanism that may be temporarily therapeutic.	• Accept the client's right to have his or her own feelings, beliefs, and point of view. • Support the client's coping mechanisms, unless they are destructive to self or others; abandoning a coping mechanism can leave a client defenseless.
Asking "How" or "Why" • Threatens or intimidates the client. • May leave the client unsure how to answer the question.	• Use open-ended questions. • Explore issues with the client so that he or she can develop insight and come to own conclusions about "how" or "why."
Asking Too Many Questions • Overwhelms the client emotionally and may invade the client's privacy or precipitate feelings of "being interrogated." • Overwhelms the client physically.	• Assess the client's physical and emotional stamina to engage in data collection. • Use several shorter sessions to collect data.
Engaging in Nonprofessional Involvement • Oversteps boundaries of the therapeutic nurse-client relationship. • Befriends the client, but actually abandons the client because the nurse is unable to fulfill professional role.	• Maintain a professional relationship with the client as the center of the health team; avoid personal and social relationships. • Minimize self-disclosure; use it judiciously. • Explain the nurse-client relationship, and set limits if necessary

III. NURSING CARE RELATED TO COMMUNICATION

Effective communication is essential when developing a therapeutic relationship with clients. The nurse should communicate with all clients in a manner that supports respect and dignity using techniques that focus on the client and client needs. Basic principles that are common to communicating with all clients and principles related to nonverbal communication are presented.

A. Therapeutic use of self:

1. Place oneself in the client's place mentally and emotionally (empathy).
2. Respect values and beliefs.
3. Maintain credibility and genuineness; be truthful, respond to needs promptly, and follow through on promises.
4. Use behaviors that exhibit active listening such as eye contact, caring facial expression, unhurried behavior, and open posture.
5. Ensure intonation and pace of words convey professional confidence, respect, interest, and acceptance of the client.

B. Environmental considerations that promote communication

1. Knock before entering a client's room, and ask permission before entering a client's closet or bedside drawer; these actions convey respect.
2. Provide privacy when communicating.
3. Reduce environmental noise and distractions.
4. Explain what is going to be done and why before entering a client's personal space; entering personal space may be perceived as a violation of a client's territory, and the client may feel uncomfortable, threatened, or anxious.

C. Interventions that facilitate communication

1. Address the client by name; avoid using terms of endearment, such as "grandma" and "honey."
2. Acknowledge the client's individuality; be flexible when meeting needs.
3. Let the client take the lead in the communication process.
4. Ensure that message is relevant and a priority for the client.
5. Stand in front of the client while making eye contact.
6. Use simple words and sentence structures; keep messages brief.
7. Repeat a message using different words if the message was not understood.
8. Use humor carefully; although it may lighten the mood, it can be misunderstood and offend a client.
9. Give the client adequate time to formulate a response to a message.
10. Seek feedback to ensure that a message is received as intended.

D. Specific interventions related to nonverbal communication

1. Be aware of a client's culture and its impact on nonverbal communication.
2. Validate the meaning of body language to ensure messages are received as intended.
3. Validate the meaning of a client's body language that is not congruent with the spoken word.
4. Use touch cautiously so as not to offend the client; touching a client enters a client's personal space; religious beliefs may prohibit being touched by a person of another gender.

V. NURSING CARE FOR CLIENTS WITH SPECIAL NEEDS

A client's physical, emotional, or cultural status may result in a diminished or absent ability to receive, process, or send a message. When impaired communication occurs between a client and a nurse, it is the nurse's responsibility to identify what is interfering with the communication process. Once the cause has been identified, the nurse can formulate an individualized plan to promote communication.

A. Clients who are angry

1. Assess for the cause of anger because all behavior has meaning.
2. Assess for verbal and nonverbal signs of escalating aggression, such as a loud voice, clenched fist and jaw, narrowed eyes, and physical agitation.
3. Model acceptable behaviors, such as keeping a calm voice with a normal volume, tone, and pace.
4. Validate the client's feelings.
5. Avoid touching the client because it may be perceived as a threat.
6. Do not turn your back to an angry client; avoid prolonged eye contact but keep the client within your visual field; position yourself between the client and the door.

B. Clients who have aphasia

1. Assess the client's ability to communicate through speech, writing, or alternative means of communication, such as gestures, a picture board, and computer programs.

2. Promote communication when the client has an inability to formulate and/or send a message (expressive aphasia).

- Use questions that require a one-word answer or a short response.
- Give the client ample time to formulate a message; do not complete sentences for the client.
- Use alternative means of communication, such as picture cards, blinking the eyes once for yes and twice for no, a computer, a puff-activated communication device, or a voice synthesizer.

3. Promote communication when the client has an inability to understand communicated information (receptive aphasia).

- Use simple words and sentences; vary words when repeating a message.
- Augment verbal messages with gestures and facial expressions.
- Augment verbal communication with picture cards or objects, such as holding up a cup of water to encourage fluid intake.

C. Clients who are confused

1. Use short sentences and convey concrete ideas.
2. Speak slowly.
3. Use questions that require a one-word answer or a short response.
4. Break down instructions into simple steps.
5. Augment verbal communication with picture cards or objects, such as holding up a comb to indicate the need for hair care.

D. Clients who are hearing impaired
1. Ensure that the client is wearing a hearing aid, if available; ensure that a hearing aid is functioning, is inserted properly, and is cleaned and stored with a label.
2. Stand on the side on which the client has more acute hearing; speak at a normal pace using a low tone because high-pitched sounds are harder to hear; use a slightly louder volume, but do not yell.
3. Face the client, enunciate words (without exaggeration), and to facilitate lip-reading avoid chewing gum or holding a hand in front of the mouth when speaking.
4. Use gestures and facial expression to augment verbal communication.
5. Determine whether the client knows sign language, and seek the assistance of sign-language specialists if applicable.
6. Provide writing materials to support communication if the client is able to write and is literate.

E. Clients who are unresponsive
1. Assume that the client's hearing is intact because hearing is believed to be the last sense lost before death. Never talk about a client or others in front of the client
thinking that the client cannot hear.
2. Talk to the client using a normal volume, tone, and pace.
3. Explain what you are going to do and the reasons why before touching a client.

F. Clients who are visually impaired
1. Provide adequate lighting.
2. Verbally inform the client when you enter or are about to leave a room.
3. Speak in a normal volume because the client is not hearing impaired.
4. Explain what you are going to do if you have to touch the client and seek permission first.
5. Orient the client to surroundings, such as furniture in room and food on a plate using a clock as a format (e.g., meat is at 12, green beans at 3, potatoes at 6).

G. Clients who do not speak English
1. Seek the help of a professional interpreter fluent in the client's language (e.g., use a telephone service that provides translation services); avoid the use of
non-educated translators or family members because inaccuracies may occur (inadvertently or deliberately) and confidentiality may be jeopardized.
2. Use a translation book that presents common questions and answers in the nurse's and client's language.
3. Use pictures, body language, and environmental cues to communicate until an interpreter is available.

H. Clients with a physical barrier (e.g., endotracheal tube, laryngectomy)
1. Encourage the client to use eye blinks; hand squeezes; writing tools, such as a magic slate; flash cards or pictures; or a communication board to communicate.
2. Reinforce and praise efforts to communicate.

V. Types of Interactions Between the Nurse and Other Health-Care Team Members

Information about clients must be communicated between nurses and among nurses and other members of the health team, including clients and their families. Whether the interaction is verbal

or written, a systematic approach is preferred so that the message is clearly, concisely, and accurately transmitted and received.

A. Systematic approach to communication

1. Framework to facilitate thorough communication among health-care professionals to provide a culture of safety for the client.
2. Current movement occurring in the health-care community toward setting standards related to interdisciplinary communication (e.g., The Joint Commission is requiring that a systematic approach be used during nursing change-of-shift reports and when a nurse seeks a telephone prescription from a primary health-care provider).
3. Example: SBAR.
a. **Situation:** Identify self, title, facility; identify client, date of birth, gender; reason for collaboration.
b. **Background:** Client's present issue, relevant medical history, summary of background.
c. **Assessment:** Vital signs and clinical indicators outside expected range, severity of client issue, nurse's clinical impression.
d. **Recommendation:** Explain what is required and urgency of what is required; make suggestions.

B. Change of shift report

1. Given by a nurse who is finishing a shift to a nurse who is responsible for continuing care of the client.
2. May be verbal, written, or audiotaped; may include walking rounds where two or more nurses visit the client as part of the report.
3. Includes basic data about the client, current assessment of the client's health status, recent interventions and client responses, dependent and independent nursing interventions to be implemented, report of clients who are off the unit temporarily (includes purpose, when they are expected to return, and nursing care that is anticipated), and clients who have been admitted, transferred, or discharged.

C. Telephone reports

1. Method by which critical information, such as laboratory test results, may be communicated to the unit.
2. Method by which nurses can report a change in a client's condition to a primary health-care provider.
3. Require the nurse to identify self by name and title, state relationship with the client, and concisely and accurately report the client's condition, including vital signs, any clinical findings, and any intervention already performed for the client.

D. Transfer and discharge reports

1. Concisely summarize all pertinent data about a client that are needed to implement immediate care.
2. Include, but are not limited to, discharge from the post anesthesia care unit (PACU); discharge to another facility, such as a nursing home or rehabilitation center; discharge to another service within the facility; and discharge from the hospital to home.

E. Reports to family members

1. Provide a progress report to designated family members; the client gives legal consent to disclose confidential information to a designated person(s).

2. A code word, functioning as a PIN number, is required from a caller before a nurse can give information over the telephone.

F. Nursing and interdisciplinary team conferences
1. Nurses and other health team members discuss a client's needs and coordinate a client's care.
2. Promote critical thinking from a multidisciplinary perspective.

G. Incident reports
1. Are required in response to any occurrence that results in or is likely to result in harm to a client, employee, or visitor.
2. Used for quality improvement activities, not for disciplinary actions against a staff member.
3. Promote identification of high-risk trends, which promote the development of educational programs to address the prevention of the problem.

VI. COLLABORATION
Collaboration is the collegial working relationship among health-care professionals in the provision of client care. It involves joint planning, decision making, goal setting, and implementation of coordinated interdisciplinary care to facilitate a more positive outcome for the client. Communication is essential among health team members because it adds an additional dimension to the communication process.

A. Components of collaboration
1. Mutual respect is essential to working collaboratively with members of an interdisciplinary team.
2. Each discipline must recognize and value the expertise that each professional brings to the partnership.

B. Personal skills essential to collaboration
1. Ability to use effective interpersonal skills.
2. Ability to keep communication open and ongoing.
3. Willingness to work with others as a team.
4. Ability to value and manage diversity.
5. Willingness to use assertive communication or engage in conflict resolution to solve mutually satisfying solutions to a problem.

VII. DOCUMENTATION

Documentation is the act of creating a written record. It involves the insertion of information about a client onto paper forms or electronically in a paperless charting system. Documentation should include information about client assessments, plans of care, interventions provided, and client responses. The written record is a legal document that also is used to promote quality assurance, reimbursement to third-party payers, education, and research.

A. Admission nursing assessment
1. Initiates a database about the client.
2. Provides information with which subsequent information can be compared.

B. Plan of care

1. A plan of care documents client's problems and strategies to reduce or eliminate them. The plan individualizes care based on assessment, problem identification, expected outcomes, and planned interventions. The plan provides a base for
evaluation.
2. May be a nursing plan of care or an integrated health team plan.
3. Is part of the client's permanent record.

C. Clinical pathways
1. Collaborative, interdisciplinary case management plan for a client with a specific medical diagnosis or procedure.
2. Includes expected outcomes, interventions to be implemented, and the sequence and timing of those interventions.

D. Flow sheets
1. Document routine aspects of nursing care.
2. Include forms, such as for vital signs, weight, I&O, skin assessment, and activities of daily living.

E. Medication administration record (MAR)
1. Documents all the client's prescribed and administered or omitted medications.
2. It contains a section to record why a drug was not administered or contains specific information relative to before or after administering a drug, such
as blood pressure before an antihypertensive and objective pain scale results before and after pain medication is administered.

F. Progress notes
1. Inform other members of the health-care team of the client's progress.
2. May use various formats.
a. Charting by exception (PIE).
(1) PIE includes:
(a) Problem identification.
(b) Interventions provided.
(c) Evaluation of client outcomes.
(2) Documents information other than routine care (routine care is documented on a separate flow sheet).
(3) Assigns a number to each identified problem, providing easy reference.
(4) Simplifies and streamlines documentation.
b. Focus charting.
(1) Uses format of data, action, and response.
(2) Ensures a focus on planning (action) and evaluation (response).
c. Case management—critical pathway.
(1) Includes key elements used by all disciplines to monitor and document interventions performed on a daily schedule so that outcomes are achieved when expected.
(2) When a goal is not met when expected because of a complication or unexpected
event (variance), the event and actions in response to the event are documented.
(3) Promotes collaboration, communication, and teamwork.
(4) Attempts to ensure that interventions are implemented as expected, increasing quality of care and discharge in a timely manner.

G. Nursing responsibilities related to documentation

1. Documentation do’s.
a. Use only acceptable abbreviations.
b. Use correct spelling and grammar.
c. Document each entry with a signature/name and title.
d. Indicate the date and time of each entry, using a 24-hour clock (military time); record events chronologically and as close as possible to the time they occur.
e. Verify that client identification is on forms before charting.
f. Record only pertinent information as concisely as possible; record facts, client statements, and nonjudgmental observations of the client’s behavior.
g. Record the client’s response to visits by health-care providers, consultants, and other caregivers, such as speech, respiratory, and physical therapists.
h. Record all telephone calls concerning the client.
i. When inserting a late entry, identify that the note is a late entry.
j. Record all care implemented and the client’s response to care.

2. Documentation don’ts.
a. Never chart interventions before they are delivered.
b. Avoid charting opinions or terms that label a client (e.g., “demanding,” “uncooperative,” and “unpleasant”).
c. Never chart for another nurse.
d. Never alter a previous entry.
e. Never backdate a note; instead, enter the current date and time with the word “addendum,” and then add the note with the date and time it should have been documented; procedures vary by facilities.
f. Avoid using the word “client” because it is unnecessary.
g. Avoid judgmental words that mean different things to different people (e.g., “good,” “poor,” “sufficient,” “decreased,” “bad,” “normal,” “abnormal”).
h. Avoid terms of generalization (e.g., “seems to be” or “appears”).
i. Do not use abbreviations that are not included in the facility’s policy and procedure manual or abbreviations disallowed by The Joint Commission.