Chapter 6

Health Team Communications

Lesson 6.1

- Define the key terms and key abbreviations in this chapter.
- Describe the rules for good communication.
- Describe the legal and ethical aspects of medical records.
- Identify common parts of the medical record.
- Explain your role in the nursing process.

Communication

- Health team members communicate with each other to give coordinated and effective care.
  - They share information about:
    - What was done for the person
    - What needs to be done for the person
    - The person's response to treatment

Communication (Cont.)

- Communication is the exchange of information.
- For good communication:
  - Use words that mean the same thing to you and the receiver of the message
  - Use familiar words
  - Be brief and concise
  - Give information in a logical and orderly manner
  - Give facts and be specific

The Medical Record

- The medical record (chart) is a written or electronic account of a person's condition and response to treatment and care.
  - It is used by the health team to share information about the person.
  - The record is permanent.
  - It can be used in court as legal evidence of the person's problems, treatment, and care.
  - Each page has the person's name, room and bed numbers, and other identifying information.

The Medical Record (Cont.)

- Agencies have policies about medical records that address:
  - Who can see them
  - Who records
  - When to record
  - Abbreviations
  - How to make entries
  - Correcting errors

The Medical Record (Cont.)

- Professional staff involved in a person's care can read and use charts.
- If you have access to charts, it is your ethical and legal duty to keep information confidential.
- The following medical record forms relate to your work:
  - Admission sheet
  - Health history
  - Flow sheets and graphic sheets
  - Progress notes and nurses' notes

The Nursing Process

- The nursing process is the method nurses use to plan and deliver nursing care.
  - All nursing team members do the same things for the person.
- The nursing process has five steps:
  - Assessment
  - Nursing diagnosis
  - Planning
  - Implementation
  - Evaluation

The Nursing Process (Cont.)

- Assessment involves collecting information about the person.
  - A health history is taken.
    - Information from the doctor is reviewed.
    - Test results and past medical records are reviewed.
  - An RN assesses the person's body systems and mental status.
  - You make many observations as you give care and talk to the person.
  - The Omnibus Budget Reconciliation Act of 1987 (OBRA) requires the Minimum Data Set (MDS) for nursing center residents.

The Nursing Process (Cont.)

- A nursing diagnosis describes a health problem that can be treated by nursing measures.
  - The RN uses assessment information to make a nursing diagnosis.
    - It is different from a medical diagnosis (the identification of a disease or condition by a doctor).
  - A person can have many nursing diagnoses.
    - They may change as assessment information changes.

The Nursing Process (Cont.)

- Planning involves setting priorities and goals.
  - Priorities are what is most important for the person.
  - Goals are aimed at the person's highest level of well-being and function.
  - A nursing intervention (nursing action, nursing measure) is an action or measure taken by the nursing team to help the person reach a goal.
  - The nursing care plan (care plan) is a written guide about the person's care.
  - OBRA requires a comprehensive care plan.
    - The plan identifies the person's problems, goals for care, and the actions to take, and it states the person's strengths.

The Nursing Process (Cont.)

- OBRA requires two types of resident care conferences:
  - Interdisciplinary care planning (IDCP) conference
  - Problem-focused conference
- The person has the right to take part in care planning conferences.
  - Sometimes the family is involved.

The Nursing Process (Cont.)

- The implementation step is performing the nursing measures in the care plan.
  - Care is given in this step.
  - The nurse uses an assignment sheet to communicate delegated measures and tasks to you.
- The evaluation step involves measuring if the goals in the planning step were met.
  - Changes in nursing diagnoses, goals, and the care plan may result.

Lesson 6.2

- List the information you need to report to the nurse.
- List the rules for recording.
- Explain how electronic devices are used in health care.

Lesson 6.2 (Cont.)

- Explain how to protect the right to privacy when using electronic devices.
- Describe how to answer phones.
- Use the 24-hour clock, medical terminology, and medical abbreviations.
- Explain how to promote PRIDE in the person, the family, and yourself.

Reporting and Recording

- Reporting is the oral account of care and observations.
- Recording (charting) is the written account of care and observations.

Rules for Recording

- Rules for reporting:
  - Be prompt, thorough, and accurate.
  - Give the person's name and room and bed number.
  - Give the time your observations were made or the care was given.
  - Report only what you observed or did yourself.
  - Report care measures that you expect the person to need.
  - Report expected changes in the person's condition.
  - Use your written notes to give a specific, concise, and clear report.

Reporting

- End-of-shift report
  - The nurse reports about:
    - The care given
    - The care that must be given during other shifts
    - The person's current condition
    - Likely changes in the person's condition
- Recording
  - Communicate clearly and thoroughly.
  - Anyone who reads your charting should know:
    - What you observed
    - What you did
    - The person's response
  - Follow your agency's policies and procedures for recording.
    - Ask for training as needed.

Electronic Devices

- Computer systems and other electronic devices collect, record, send, receive, and store information.
- The right to privacy must be protected.
- When using computers and other electronic devices, you must:
  - Follow the agency's policies
  - Maintain the confidentiality of protected health information (PHI)
  - Maintain the confidentiality of electronic protected health information (ePHI, EPHI)

Phone Communications

- When answering phones, you need good communication skills.
  - You need to:
    - Be professional and courteous
    - Practice good work ethics
    - Follow the agency's policy

Medical Terminology and Abbreviations

- Medical terms are made up of parts or word elements.
  - A term is translated by separating the word into its elements.
- Prefixes, roots, and suffixes
  - A prefix is a word element placed before a root.
  - The root contains the basic meaning of the word.
  - A suffix is placed after a root.
  - Medical terms are formed by combining word elements.

Medical Terminology and Abbreviations (Cont.)

- Directional terms
  - Anterior (ventral): At or toward the front of the body or body part
  - Distal: The part farthest from the center or from the point of attachment
  - Lateral: Away from the mid-line; at the side of the body or body part
  - Medial: At or near the middle or mid-line of the body or body part
  - Posterior (dorsal): At or toward the back of the body or body part
  - Proximal: The part nearest to the center or to the point of origin

Medical Terminology and Abbreviations (Cont.)

- Medical abbreviations
  - Abbreviations are shortened forms of words or phrases.
  - Each agency has a list of accepted medical abbreviations.
    - Use only those accepted by the agency.
    - If you are not sure that an abbreviation is acceptable, write the term out in full.