

A Communication Skills Module: **Documenting & Reporting Client Care**

INSTRUCTIONS FOR THE SUPERVISOR

Step One:

- Make a copy of the Instructions for the Learner page. Return your original to the sheet protector. Add the following information to the copy:
 1. The name (or position) of the person to whom the aides should direct questions.
 2. The name (or position) of the person to whom the aides should turn in their quizzes.
 3. The date by which the quiz page should be turned in.
 4. The name (or position) of the person who will initial the aides' Inservice Club Membership Cards.
- Use this copy as your "master" as you make up the inservice packets.

Step Two:

- Have the following copied for each learner:
 1. The **Instructions for the Learner** page.
 2. The **11 Page** Inservice newsletter.
 3. OPTIONAL: Your workplace policies on handling charting errors and writing incident reports, and your workplace list of approved abbreviations.
 4. The **Quiz** page.

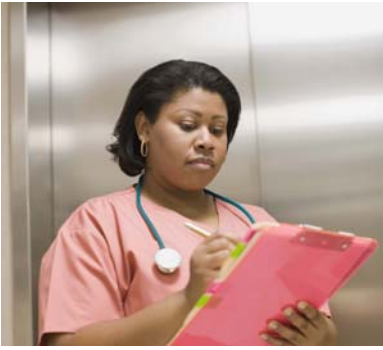
Step Three:

For Self-Study Use

- Distribute as desired—in employee mailboxes; folded in paychecks, etc.
- You may want to post the Quiz Answer Sheet in a prominent spot.

For Group Use

- Read over the Suggested Participatory Activities, the Suggested Teaching Tips and the Suggested Discussion Questions.
- Select the activities you want to use during your inservice hour.



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SUGGESTED PARTICIPATORY ACTIVITIES

ACTIVITY # 1: HIDDEN OBJECTS—A TEAM BUILDING ACTIVITY

Use this activity to improve observation and descriptive writing skills. Play in groups of 2-3 and encourage collaboration between group members.

- **What you'll need:** Three (3) medium sized boxes with holes cut in the top (holes should be large enough to fit a hand and arm in without revealing what's inside). Three (3) "odd" objects (Suggestions for objects listed below.) and a piece of paper and pen for each person.
- Remind the group that observation involves using the senses. When one sense is blocked (vision in this case), other senses become heightened. You can compare this to closing your eyes in order to count a difficult pulse.
- Have each individual place a hand inside each box, one at a time and try to guess what is inside. Allow discussion among group members to come up with the answer!
- If they know what's inside they should write it on the paper. If they can't figure out what is inside, they should write the best description possible using words like smooth, rough, prickly, etc.
- Once everyone has had a chance to feel the objects and write down their answers, reveal the objects and discuss the observations.
- Suggested objects: a digital thermometer, catheter tubing, a rolled up ace bandage, a pinecone, a twig, a cell phone (turned off), a toy truck. Use your imagination . . . look for objects that will challenge your particular group!

ACTIVITY # 2: PRACTICE MAKES PERFECT!

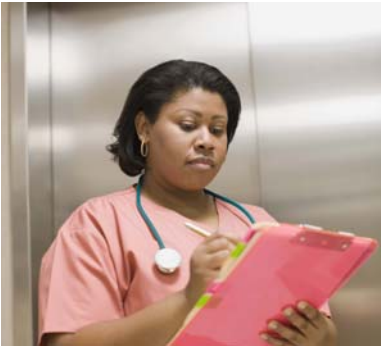
Use this game to reinforce good documentation practices—and to remind the group how easy it is to make a silly mistake.

- Decide if you want your employees to work individually or in small groups. Then, make enough copies of the "Practice Makes Perfect" worksheet to go around.
- Allow 10 to 15 minutes for them to complete the worksheet. Stress that this is for fun—and not for a grade.
- When everyone is finished, go over the "correct" answers as a group.

ACTIVITY # 3: HOW WOULD YOU DOCUMENT...?

Ask the group for suggestions for handling the following documentation challenges:

- A client's daughter yells at you and accuses you of stealing her mother's money. How would you write about this situation?
 - You make a home health visit and your client has no food in his refrigerator. He tells you he's not hungry anyway. How would you document this situation?
 - When you help your client turn over, you notice some loose medication capsules in her bed. What would you say in your documentation?
-



Developing Top-Notch CNAs, One Inservice at a Time

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SUGGESTED TEACHING TIPS

TEACHING TIPS

- Make an overhead of the Quiz Answer Sheet and the Practice Makes Perfect answer key.
- Take advantage of this inservice time to go over your workplace policies on handling charting errors and writing incident reports.
- Take some time to allow participants to discuss their reaction to:
 - The “Talk About It” box on page 5,
 - The “Connect it Now” box on page 6, and
 - The “Think About It” box on page 7.
- Pass copies of clinical forms around to the group, reviewing your workplace rules for completing these forms.
- Post a correctly completed sample form (such as flow sheet or visit note) in a break room or employee bathroom.
- Have CNA’s participate in peer review of clinical records. They’ll contribute to the performance improvement process and reinforce their knowledge of documentation at the same time.

RESOURCES

The following resources were used in developing this inservice. You might want to check them out for further information:

- [Essentials for Today’s Nursing Assistant](#) by Peggy A. Grubbs
- [Charting Made Incredibly Easy!](#) by Springhouse Corporation
- [The New Nursing Assistant](#) by Barbara Gillogly, Ph.D., Ed.
- [Home Care Aide](#) by Mosby Lifeline
- [Home Care Aide](#) by Joan Birchenall & Eileen Streight
- Nurse’s Service Organization at www.nso.com
- National Association for Home Care and Hospice at www.nahc.org
- American Nurses Association at www.nursingworld.org
- Center for Medicaid and Medicare Services at www.cms.hhs.gov

PLEASE NOTE:

Your staff may enjoy the following related In the Know inservices:

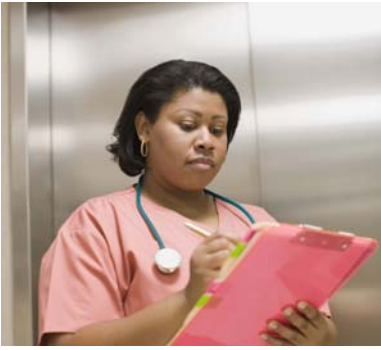
- How to Prioritize your Work
- Working with a Team
- Critical Thinking Skills
- Health Care Ethics
- Medical Terminology and Abbreviations
- Professionalism and Work Ethic
- Time Management Skills
- Understanding the Survey Process
- Maintaining Confidentiality
- Preventing Medical Errors

If your In the Know library doesn’t include these titles, they are available for purchase by calling our toll-free number:

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SUGGESTED DISCUSSION QUESTIONS

DISCUSSION QUESTION #1

Ask the group to read the story about “Caroline” at the beginning of the Learner Packet. Discuss what went wrong and how Caroline’s death could have been avoided.

Answer: The **first** thing that went wrong was that Caroline felt pain in her legs but did not report it. Does this mean Caroline is responsible for her own death? NO! She is in the facility to be cared for by professionals. She should not be expected to know that leg pain and swelling after a major surgery could be a sign of DVT.

The **second** thing that went wrong was the inaccurate chart entry that Caroline was comfortable in bed with stocking on. This is an inaccurate and false report. If the staff had actually checked on Caroline, the stockings would have been put back on and Caroline may have mentioned the pain. Intervention could have saved her at that point.

The **final** thing that went wrong was the discovery of abnormal vital signs without an immediate verbal report to the nurse. Had a verbal report been made at that time, intervention could have been started and death could have possibly been avoided.

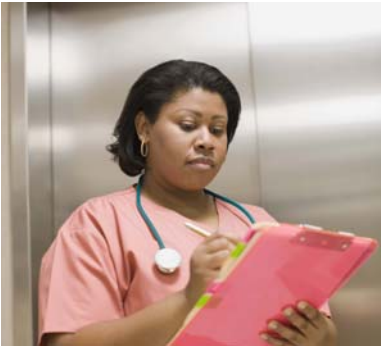
DISCUSSION QUESTION #2

If you feel responsible for a client’s injury, should you say so in an incident report? Why or why not?

Incident reports should include only the facts—not your opinions. For example, let’s say that you promised Mr. Walker you’d be back in 10 minutes to help him to the bathroom. You arrive in his room two minutes late, and find Mr. Walker on the floor. You feel guilty—and are sure that if you’d gotten to his room on time, Mr. Walker wouldn’t have gotten hurt. When filling out the incident report, you say, “I was two minutes late returning to Mr. Walker’s room. He had to go to the bathroom and couldn’t wait. He tried to get up by himself and fell down. I’m sorry.” This may be how you feel, but these are not facts! Here’s a better way to describe the incident: “When I left Mr. Walker’s room at 0800, he was resting comfortably in bed. When I returned to his room at 0812, I found Mr. Walker on the floor next to his bed. I rang for help immediately.” Remember . . . even if you feel responsible, you don’t know what went on in Mr. Walker’s room while you were gone. He may have tried to get up the minute you left his room. He may have rolled over and fallen out of bed. So, don’t write what you think happened. Stick to the facts!

HERE ARE MORE QUESTIONS THAT MAY SPUR SOME INTERESTING DISCUSSION:

- Do you think computers make documentation easier or more difficult? Why?
- Do you think computers can reduce errors associated with documentation? Give an example.
- Do you think there are too many different forms used for documenting client care at your workplace? If so, which ones do you think could be safely eliminated? Why?
- Do you think enough care is taken at your workplace to keep medical records confidential? If not, can you think of ways to improve the system?



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QUIZ ANSWER KEY

- 1. False**
It's best to document immediately after performing care, that way observations are fresh in your mind.
- 2. False**
You may **ONLY** use abbreviations approved by your workplace. Never make up your own—the other members of the team will not know what you are trying to say.
- 3. False**
If your client refuses care, you should document that the client refused care and verbally report to your supervisor for further instructions. If you don't document anything it will look as if you didn't even offer the care in the first place.
- 4. True**
After making an oral report, you **MUST** document the name and title of the person you reported to.
- 5. Your client tells you, "I'm sick of living in pain like this," you should report:**
C. "Client reports, 'I'm sick of living in pain like this.'" You should just report the facts. You don't know if your client is suicidal . . . this is an opinion. And, you should never put something negative about a co-worker in a medical chart.
- 6. False**
NEVER use "white-out" in a medical chart! Report the problem to your supervisor right away and refer to your workplace policy on handling charting errors. **DO** document on the correct client chart right away.
- 7. True**
An example of an objective observation is: "Temp. 99.6, pulse 74, resp. 16." Objective observations are those that can be seen, heard, smelled, felt or measured.
- 8. False**
Keeping documentation confidential in a Home Health setting is **JUST AS** important as other settings.
- 9. True**
It is never okay to document care before you give it, even if you do the same thing every day. If you get busy and are unable to perform the care you already documented . . . you have falsified the record!
- 10. Fill in the Blanks**
A report that describes and unexpected event that involves an accident or injury is called an **INCIDENT** report.



Developing Top-Notch CNAs, One Inservice at a Time

*A Complete Civility Training Program: **The Real Healthcare Reform***

AND ALSO FROM IN THE KNOW...

CIVILITY TRAINING PROGRAM PACKAGES

How Many	Your Cost*
12	\$182.26
24	\$271.77
50	\$449.00
100	\$742.00
150	\$898.50
300	\$1,497.00

WHAT YOU'LL GET:

- A copy of *The REAL Healthcare Reform* for each of your learners
- The Companion Instructor's Manual
- Engaging classroom activities and discussion questions
- Convenient PowerPoint presentations
- Tips for improving participation and keeping yourself organized
- A CD with master PDF copies of all the handouts and presentations
- SIX HOURS of inservice credit for your CNAs

* Plus shipping

ARE YOU READY TO DELIVER A COMPREHENSIVE CIVILITY TRAINING PROGRAM WITHIN YOUR WORKPLACE?

Did you know the Joint Commission recommends that all accredited healthcare organizations be responsible for handling and preventing incivility in the workplace?

Civility training in the healthcare workplace is more than just a course in professional conduct—although professional conduct is the goal! Civility training teaches:

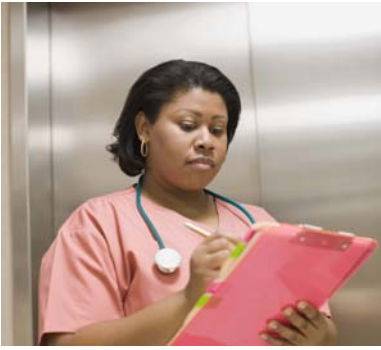
- Self-awareness
- Personal and professional integrity
- Communication skills
- A sense of ownership in the workplace
- Personal empowerment to solve problems with energy, creativity and enthusiasm

Based on the bestselling book "The Real Healthcare Reform," our Civility Training Program is unique because it immerses learners in the material in a fun and engaging way. **The program is written for all healthcare employees, clinical and non-clinical, and will benefit everyone in your organization.**

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EVALUATION

Employee Name _____

Date _____ **Self-Study Inservice** **Group-Study Inservice**

1. Put a checkmark in the box that best describes how you feel about each learning objective.

LEARNING OBJECTIVE	I am able to do this.	I might be able to do this.	I can't do this.	I'm not sure.
<i>Name at least three purposes of clinical documentation.</i>				
<i>Describe the difference between objective and subjective observations.</i>				
<i>Discuss the five rules of clinical documentation.</i>				
<i>Describe the purpose of an incident report.</i>				
<i>Complete your documentation according to the guidelines presented in this inservice and the policies of your workplace..</i>				

2. Did you learn anything new that will help you in your job? Yes No

If yes, please explain: _____

3. If you have questions about the inservice information that did not get answered, note them here:

4. Other comments? _____

