

## Unit 5: Communication and

### Collaboration Lesson 1: Written Communication

#### Introduction to Professional Written Communication

Successful healthcare practice requires the ability to communicate effectively. Written communication may be exchanged among providers, clients and co-workers through charting, emails, and other documents.

In addition, while in school, there may be written assignments that will use the APA format. APA Style supports “concise, powerful, and persuasive scholarly communication” (APA, 2020, p. 1) and the *APA Manual* (APA, 2020) will be a required resource throughout your nursing education at Chamberlain.

This concept will review various forms of written communication for the clinical setting along with student-related written assignments.

#### Written Communication – Do’s and Don’ts

Written communication is the most common, and sometimes the only, means of communication between healthcare professionals.

Written communication has many advantages beyond verbal communication:

- Information can be used for future reference purposes and can be easily shared among multiple providers.
- Information can be used for legal purposes to document care that was provided and to also audit and improve the delivery of care as needed.
- Using electronic written communication allows for even more immediate access to information and avoids the need for a verbal connection.

| Written Communication “Do’s”   | Written Communication “Don’ts”   |
|--|--|
| <ul style="list-style-type: none"><li>• Use time and date, and be specific, accurate, and complete</li><li>• Use a black pen versus blue or other colors on handwritten charts</li><li>• Document any care that was provided in a timely fashion</li><li>• Correct errors promptly</li><li>• Document facts, and avoid judgmental terms</li><li>• Follow grammar and punctuation rules</li><li>• Use only approved medical terms and abbreviations</li></ul> | <ul style="list-style-type: none"><li>• Erase, use correction fluid, or scratch out errors</li><li>• Use blue ink when using handwritten charts</li><li>• Share passwords</li><li>• Document opinion or speculate</li><li>• Falsely document</li><li>• Document using another nurse’s information (from a previous shift)</li><li>• Pre-chart to save time</li><li>• Use generalized empty phrases</li></ul> |

(Vermeir et al., 2015)

The following are basic rules for documenting:

- Use time and date; be specific, accurate, and complete
- Follow rules of grammar and punctuation
- Chart as soon and as often as necessary
- Chart your own care, observations, and teaching
- Correct errors promptly
- Use black ink when using handwritten charts

You should not use blue ink, erase, use correction fluid, or scratch out errors. You should not chart only once at the end of the shift.

### Record Keeping: Forms & Examples

There are several different types of forms used for record keeping. The forms can be a paper chart or an electronic version of the chart.

Click each tab for a definition and example of each form.

- **Kardex:** This form/system is used to condense patient orders and is typically found in long-term care (LTC) facilities. It includes a 24-hour snapshot of the client's care including diet, activity, elimination, supportive devices, wound care, and hygiene.
- **Nursing Care Plan:** This is developed to meet the nursing care needs of the client using the nursing process. Each nursing issue is documented with a plan of care to address the client's problem/issue and improve their health outcomes.
- **24-Hour Client Care Records and Acuity Charting Forms:** This form is used to document all of the vital information for a 24-hour period, including vital signs, intake and output, hygiene, and diet. An acuity chart would rate the level of acuity for the client from 1-5, with 1 being a higher acuity (complete care) and 5 a lower acuity (self-care).
- **Discharge Summary Form:** This form is used to adequately ensure the client is ready for discharge. Ideally, discharge planning begins upon admission. The client must be given the discharge instructions, which will be written concisely and clearly.

**Becoming a Better Writer:** As a student, you will be frequently asked to communicate through the written, or typed, word. Your writing expertise will grow with practice and experience. Consider trying a couple of these tips to start, and later add more to your skill set until you become an expert writer.

The following tips (McAfoos, 2015) will help improve your writing skills. Select each tip below to learn more!

- **Creating Talking Points:** Develop an outline of your ideas before you begin. Construct a list of points you want to make throughout your paper. Later, when you review your work, check off these points to be sure that you have covered them all.
- **Wait to Review:** Once you have finished your writing, it's tempting to give it a quick check and submit it. Instead, allow time to pass before you re-read it. This lets you