Nursing level III

NTQF III

Learning Guide-42

Unit of Competence: Provide Palliative Care and Maintain Mortuary Service

Module Title: Providing Palliative Care and Maintain Mortuary Service

LG Code: HLT NUR3 M08 LO1-LG-01

Code: HLT NUR3 M08 TTLM0919V2

LO 4: Release bodies to Funeral Director/ Conveyors

Instruction Sheet 1	Learning Guide #1

This learning guide is developed to provide you the necessary information regarding the following **content coverage** and topics:

- Flow Policy and procedures for handling and storage of bodies
- Respecting Cultural and religious considerations

This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, upon completion of this Learning Guide, you will be able to:

- Flow Policy and procedures for handling and storage of bodies
- Respect Cultural and religious considerations

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below 3 to 6.
3. Read the information written in the information "Sheet 1, Sheet 2, Sheet 3, Sheet 4, Sheet 5, Sheet6 and Sheet 7".
4. Accomplish the "Self-check 1, and Self-check t 2." **in page -6 and 9**

Information Sheet-1	Flow Policy and procedures for handling and storage of bodies

4.1. Flow Policy and procedures for handling and storage of bodies

4.1. Documentation

Documentation is anything written or printed on which you rely as record or proof of patient actions and activities

A record or chart or client record is a formal, legal document that provides evidence of a client's care and can be written or computer based.

A report is oral, written, or computer-based communication intended to convey information to others.

The process of making an entry on a client record is called recording, charting, or documenting

Each health care organization has policies about recording and reporting client data, and each nurse is accountable for practicing according to these standards.

Purposes Documentation

The patient record is a valuable source of data for all members of the health care team. • Client records are kept for a number of purposes including:

- Communication
- Planning client care
- Auditing health agencies
- Research
- Education
- Reimbursement
- Legal documentation
- Health care analysis

Communication The record serves as the vehicle by which different health professionals who interact with a client communicate with each other. This prevents fragmentation, repetition, and delays in client care.

PlanningClientCare Each health professional uses data from the client's record to plan care for that client. Nurses use baseline and ongoing data to evaluate the effectiveness of the using care plan.

Auditing Health Agencies An audit is a review of client records for quality assurance purposes. Accrediting agencies such as The Joint Commission may review client records to determine if a particular health agency is meeting its stated standards.

Researchthe information contained in a record can be a valuable source of data for research. The treatment plans for a number of clients with the same health problems can yield information helpful in treating other clients.

Education Students in health disciplines often use client records as educational tools. A record can frequently provide a comprehensive view of the client, the illness and effective treatment strategies.

Reimbursement Documentation also helps a facility receive reimbursement from the government. For a patient to obtain payment through Medicare or insurance agencies the client's clinical record must contain the correct diagnosis and reveal that the appropriate care has been given.

Legal Documentation The client's record is a legal document and is usually admissible in court as evidence.

Health Care Analysis Information from records may assist health care planners to identify agency needs, such as over utilized and underutilized hospital services. • Records can be used to establish the costs of various services and to identify those services that cost the agency money and those that generate revenue.

GUIDELINES / PRINCIPLES OF RECORDING

Guidelines/ principles:

1. Factual
2. Timing
3. Legibility
4. Permanence
5. Accepted terminology
6. Correct signature
7. Spelling
8. Accuracy
9. Sequence
10. Appropriate
11. Complete
12. Concise
13. Legal prudence

FactualA factual record contains descriptive, objective information about what a nurse sees, hears, feels, and smells. Avoid vague terms such as appears, seems, or apparently because these words suggest that you are stating an opinion, do not accurately communicate facts. Objective documentation includes observations of a patient's behaviors.

DateandTime Document the date and time of each recording this is essential not only for legal reasons but also for client safety. Record the time in the conventional manner (e.g., 9:00 AM or 3:15 PM) or according to the 24-hour clock (military clock), which avoids confusion about whether a time was AM or PM

Legibility All entries must be legible and easy to read to prevent interpretation errors. Hand printing or easily understood handwriting is usually permissible.

PermanenceAll entries on the client's record are made in dark ink so that the record is permanent and changes can be identified. Follow the agency's policies about the type of pen and ink used for recording.

AcceptedTerminology People in the 21st century are often in a hurry and use abbreviations when texting. Even though using abbreviations is convenient, medical abbreviations have been responsible for serious errors and deaths .

CorrectSpelling Use correct spelling while documenting. Correct spelling is essential for accuracy in recording. Avoid spelling mistakes

Signature Each recording on the nursing notes is signed by the nurse making it. The signature includes the name and title; for example, "M.S. REDDY, RN"

Accuracy The client's name and identifying information should be stamped or written on each page of the clinical record. When a recording mistake is made, draw a single line through it to identify it as erroneous with your initials or name above or near the line (depending on agency policy). Do not erase, blot out, or use correction fluid. • The original entry must remain visible

Sequence Document events in the order in which they occur; for example, record assessments, then the nursing interventions, and then the client's responses.

Appropriateness Record only information that pertains to the client's health problems and care. Any other personal information that the client conveys is inappropriate for the record.

Completeness Not all data that a nurse obtains about a client can be recorded. However, the information that is recorded needs to be complete and helpful to the client and health care professionals.

Conciseness Recordings need to be brief as well as complete to save time in communication. Repeated usage of the client's name and the word client are omitted.

LegalPrudence Accurate, complete documentation should give legal protection to the nurse, the client's other caregivers, the health care facility, and the client. Admissible in court as a legal document, the clinical record provides proof of the quality of care given to a client.

Self-Check -1	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page

1. List out Purposes Documentation.(4 points)
2. List out Guidelines/ principles of recording.(5 points)

Note: **Satisfactory rating - 3 and 5 points   Unsatisfactory - below 3 and 5 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Score = ____________
Rating: _____________

Name: ___________________________   Date: ________________

Short Answer Questions

Answer sheet

1____

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2____

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3____

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Information Sheet-2	Cultural and religious considerations

4.2. Cultural and religious considerations

Cultural Concerns in Nursing Being aware of or inquiring about a person's cultural or religious beliefs with respect tomedical care can help nurses avoid causingcultural pain to patients. These concerns mustbe a priority when caring for patients and mustbe respected in order to gain a patient's trustand to be able to holistically care for them.Caring for patients not only focuses on thephysical aspect of health, but must also includethe mind and spirit as well.

CultureShared system of beliefs, values, and behaviouralexpectations that provide social structure fordaily living.

Cultural DiversityIt is the cultural variety and differences thatexist in the world, a society or an institution. Itis having a group of diverse people in one place.People working or living together that havedifferent cultures.

Cultural Sensitivitybeing aware that cultural differences and similaritiesexist and that they can have an effect ofbehaviour, values and learning. It also means to beaware and tolerant of these differences andacknowledging them when interacting with others. StereotypingCategorizing individuals or groups of people into anoversimplified or standardized image or idea. It'swhen you assume that a belief or characteristic isshared by all in one class, culture or ethic group.

Culturalbiasto give an advantage to one cultural overanother. To ignore the differences betweencultures and impose understanding based onthe study of one culture to other cultures. Tothink one culture has precedence of the other.

Cultural Influences on Healthcare

- Physiologic Characteristics
- Psychological Characteristics
- Reactions to Pain
- Gender roles

- Language and communication
- Orientation to space and time
- Food and nutrition
- Socioeconomic Factors

Physiologic CharacteristicsCertain racial groups are more prone to specific diseasesand conditions.

Examples include:

- Keloids
- Lactase deficiency and lactose intolerance
- Sickle cell anemia

Psychological CharacteristicsIn most situations, a person interprets the behaviours of another person in terms of her orhis own familiar culture.

Languageandcommunication

To avoid misinterpretation of questions and answers, it is important to use an interpreter who understands the healthcare system. When caring for culturally and ethnically diverse patients it is important to perform a transcultural assessment of communication.

Cultural assessment when caring for patients from a differentculture, it is important to find out how theywant to be treated based on their cultural valuesand beliefs. An effective way to identify specificfactors that influence a patient's behaviour is toperform a cultural assessment.

Guidelines for CareCultural competency is a process and takes time. It involves developingawareness, acquiring knowledge, and practicing skills. As defined by, the nurses should answer the

Self-Check -1	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. List out Cultural Influences on Healthcare.(8 points)

Note: **Satisfactory rating - 3 and 5 points Unsatisfactory - below 3 and 5 points**

You can ask you teacher for the copy of the correct answers.

Answer Sheet

Score = ____________

Rating: _____________

Name: ___________________________   Date: ________________

Short Answer Questions

Answer sheet

1____

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2____

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3____

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List of Reference Materials

1. http://www.culturediversity.org/index.html
2. http://www.barnesjewish.org/about/diversity
3. http://www.apa.org/about/gr/issues/socioeco

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