Task for Nurse Practitioners

Maintain complete and detailed records of patients' health care plans and prognoses.

<https://www.onetonline.org/link/summary/29-1171.00>

Describe the task as far as you can, indicating what else you would need to know to be able to design an effective sequence of pedagogic tasks.

According to O\*Net, the following work activities could be related to this task:

**Documenting/Recording Information** — Entering, transcribing, recording, storing, or maintaining information in written or electronic/magnetic form.

**Getting Information** — Observing, receiving, and otherwise obtaining information from all relevant sources.

**Analyzing Data or Information** — Identifying the underlying principles, reasons, or facts of information by breaking down information or data into separate parts.

**Processing Information** — Compiling, coding, categorizing, calculating, tabulating, auditing, or verifying information or data.

Examples of common forms or charts that might need to be completed for record keeping:

Patient admission form

Patient record

Wound assessment chart

Diabetic chart

Pathology report

Medication or Prescription chart

Pre-Op checklist

Fluid Balance chart

Universal Pain assessment tool

Referral form

Katz ADL index

Discharge plan

(from Allum & McGarr, Cambridge English for Nursing, CUP 2008.)

As far as I know, these are forms or charts that would have to be completed to fulfil the task. The completion can be done on paper or electronically, which might need special training to use the technology correctly.

I would need to know which forms my students actually really have to complete or rather, which information from these charts they would have to convey in English, since all charts are actually in German in German hospitals, as far as I know. (This has just been a light-bulb moment. Why do I teach them abbreviations to complete charts in English when they never do this?)

Relevant sources would include the patient and/or their next of kin, possibly their health insurance provider, GP or referring specialist or treating physician.

I would also need to know how the nurse obtains the information: face-to-face or telephone interview, from a letter of referral or any other source.

Furthermore, information about how often each chart is filled in and which of those charts are more complicated or easier to complete may be relevant. Which of these is the most referred to form by other professionals?

Questions for domain experts about this task: Maintain complete and detailed records of patients' health care plans and prognoses.

For whom do you keep these records?

Who starts to keep the records?

Are those records only in written form?

When will the records be filled in? During the ward round? Later? By how many different people? What do these people talk about regarding each patient?

Which data will be recorded (vital signs, medication, other?)

Which abbreviations are used and how important is it to use them?

If you have an English-speaking patient, will records be kept in German only?

On which occasions do you provide written data in English?

How often do you speak English with a patient?

Do you have a checklist to follow for interviews in English to complete any of the forms above?

Thank you, Katja, for you input!