PRINCIPLES OF CAREGIVING: FUNDAMENTALS

CHAPTER 6 – OBSERVING, REPORTING AND DOCUMENTING

CONTENTS

OBJECTIVES

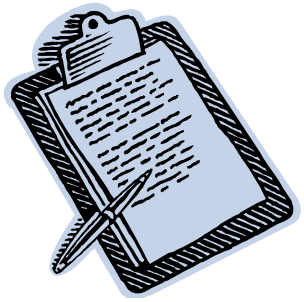
1. Explain the purpose of reporting and documentation.
2. Describe the purpose of care and support plans.
3. Explain the importance of observing changes in a person and describe observation techniques.
4. Identify and explain signs and symptoms that need to be reported.
5. Prepare written documentation following documentation guidelines.

KEY TERMS

Care plan	Sign
Charting	Reporting
Documentation	Support plan
Progress notes	Symptom

A. PURPOSE AND IMPORTANCE OF OBSERVING AND REPORTING

The purpose of observing, reporting, and documenting is to communicate any changes or status that may be occurring with an individual and/or the family. Since the individual may even be unaware of changes, it is vitally important for the DCW to communicate with other team members (including the person's family, as appropriate). This can be accomplished through **observing** and monitoring for any changes, and **reporting** and **documenting** those changes.



Report and document only things that you saw or did YOURSELF. The information that is communicated will help the supervisor act appropriately. The DCW becomes the "eyes and ears" for the supervisor. The DCWs *accurate* input is vitally important.

B. OBSERVING AND MONITORING

1. Recognizing Changes – The DCW as Detective

- Early identification of changes in an individual's daily routines, behavior, ways of communicating, appearance, general manner or mood, or physical health can save his or her life.

- You get to know a person by spending time with him or her and learning what is usual for them. If you don't know what is normal for a person, you won't know when something has changed.

Tools the DCW may use

- **Observation:** Use all of your senses: sight, hearing, touch and smell.

- **Communication:** Ask questions and listen to answers. A good listener hears the words and notices other ways of communicating, including behavior.

2. Signs and Symptoms of Illness or Injury

Signs are what can be observed; *symptoms* are what the person experiences or feels.

Physical Health: Changes in physical health are often identified by changes in a particular part of the body. Some are changes you may observe, and others are changes an individual may tell you. For example, you may observe that an individual is pulling his ear or an individual may tell you that his ear hurts.

> Ask yourself: *Is there any apparent change to the individual's skin, eyes, ears, nose, or any other part of the body?*

Physical changes to pay attention to include:

- **Skin**: Redness, cut, swelling, rash.
- **Eyes:** Redness, yellow or green drainage, swelling of the eyelid, excessive tearing, or the individual reports pain and/or that eyes are burning.
- **Ears**: Pulling at ear, ringing in the ears, redness, fever, diminished hearing, and drainage from the ear canal, the individual reports dizziness or pain.
- **Nose**: Runny discharge (clear, cloudy, colored), rubbing of nose.
- **Mouth and throat**: Refusing to eat, redness, white patches at the back of the throat, hoarse voice, fever or skin rash, toothache, facial or gum swelling, gum bleeding, fever, individual reports pain when swallowing.
- **Muscles and bones**: Inability to move a leg or an arm that the individual could previously move, stiffness, limited range of motion, individual reports pain in the arms, legs, back.
- **Breathing (lungs)**: Chest pain, cough, phlegm (mucous), shortness of breath or wheezing, fever, rash, stiff neck, headache, chills, nasal congestion, individual reports pain in nose or teeth, dizziness.
- **Heart and blood vessels**: Numb or cold hands or feet, swelling of ankles, chest pain, shortness of breath.
- **Abdomen, bowel, and bladder (stomach, intestines, liver, gallbladder, pancreas, urinary tract)**: Constant or frequent abdominal pain, bloating, vomiting, loose stools or diarrhea, constipation, blood in vomit or stools, fever, fruity smelling breath, difficult, painful and/or burning urination, changes in urine color (clear to cloudy or light to dark yellow), fruity smelling urine, nausea, pain on one or both sides of the mid-back, chills.
- **Women's health**: Vaginal discharge, itching, unusual odor, burning, changes in menses, such as change in frequency, length, and flow.
- **Men's health**: Discharge from penis, pain, itching, redness, burning.

Warning signs of injury that require medical attention:

- **Joint deformity:** Limb is out of alignment with the rest of the extremity.
- **Joint pain or tenderness:** Finger pressure to the area causes pain.
- **Swelling:** Swelling within a joint causes pain and can even cause a clicking noise as the structural tendons and ligaments get pushed into new positions.
- **Decreased range of motion** of the affected joint or limb.

- **Numbness or tingling:** This may be a sign of nerve compression.

For treatment of injuries, refer to Chapter 9, Fire, Safety and Emergency Procedures.

3. Changes in Mental or Emotional Status

- **Behavior**: An individual who is usually calm starts hitting and kicking; appears more or less active than usual.

  Ask yourself: *Does the individual appear more or less active than usual? Is the individual acting aggressively to himself or to others?*

- **Ways of communicating**: An individual who usually talks a lot stops talking; speech becomes garbled or unclear.

  Ask yourself: *Has the individual's ability to talk or communicate changed?*

- **Appearance**: An individual who is usually very neat in appearance now has uncombed hair; is wearing a dirty, wrinkled shirt. There are changes in color or appearance (a sudden redness on the hands or an ashy tone and clammy feel to the skin); any changes in weight, up or down.

  Ask yourself: *Does it seem like the individual has lost interest in things? Is the individual taking less care in his or her dress?*

- **General manner or mood**: Someone who is usually very talkative and friendly becomes quiet and sullen; an individual who usually spends her free time watching TV with others suddenly withdraws to her room and wants to be alone.

  Ask yourself: *Has the individual's mood changed? Does the individual want to be alone all the time?*

- **Family/social relationships**: The individual may act distant or afraid when family members or visitors are around.

  Ask yourself: *Is there someone interacting with the person who appears to causing emotional distress*? If you notice any signs of drug activity, or verbal or physical abuse, inform your supervisor immediately.

4. Changes in Home Environment

- **Finances**: Are there unpaid bills? Have utilities been cut off? Is there sufficient food on hand?

- **Cleanliness**: Has there been a change in housekeeping routines? Can the individual continue doing household chores?

- **Home maintenance/safety**: Are there repairs that need to be done that could cause a health or safety hazard?

Source: The section on observing and monitoring was adapted from: Direct Care Worker Training, California Department of Developmental Services.

Reporting Equal Win/Win for Client and Caregiver

Learning to communicate effectively with an individual and your supervisor is key to maintaining a good caregiving relationship. As a caregiver, you learn to adapt and respect each client's daily routine; however, as a client's level of care may begin to change, there may need to be adjustments to ensure the safety of the person and the caregiver are not compromised. As a caregiver, your communication and reporting is very valuable to identify any changes so that your supervisor can respond with a plan of action and also communicate with client's case manager.

As a caregiver supervisor working in this field over eight years, I recall a win/win situation for one client and caregiver based on effective communication and reporting.

My story begins with the caregiver who has been providing care for her client for over four years. Over time Mary began noticing that managing the daily routine began taking longer and longer as her client's abilities were lessening. The caregiver reported her concerns with her supervisor, and the supervisor scheduled a home visit to meet with the client and caregiver to observe the morning routine. Upon completing the home visit, it was apparent to the supervisor that the caregiver did not have the tools and time necessary to meet the client's needs. The supervisor contacted the client's case manager. Another visit was scheduled with the case manager, supervisor, client, client's daughter, and caregiver to meet together in client's home to discuss face to face what changes could be implemented into the client's routine, so both client and caregiver were safe and the client would be receiving good care. The case manager completed a new assessment and submitted orders for the client to receive a hospital bed, Hoyer lift, new wheelchair and cushion and a new shower chair. The client's hours of service were increased to have coverage seven days a week, with a morning and evening schedule. Communication and reporting got this snowball going and it all paid off in the end with the win / win for both client and caregiver.

Bonnie Zanardi, caregiver supervisor

C. CARE PLANS AND SUPPORT PLANS

- A *care plan* or *support plan* (depending on the agency terminology) is a written plan created to meet the needs of the person. It may also be called a service plan.
- The plan is usually created during an in-home assessment of the individual's situation, the strengths and care being provided by family and friends.
- The plan defines the needs and objectives/goals for care.
- The plan lists the actions to be provided by the DCW.
- Any deviations from a care or support plan may put the DCW at risk for disciplinary action. **Therefore, any changes need to be approved by the supervisor.**
- Care/support plans are reviewed by the care team. The DCW may be asked for input as to how the plan is working. Reporting and documenting are very critical in evaluating whether the plan is working or if it needs revision.

D. REPORTING

Now that you have observed changes or monitored the person's status the DCW needs to *report* the changes. *Reporting* is the verbal communication of observations and actions taken to the team or supervisor, usually in person or over the phone. A verbal report is given to a supervisor when the need arises, or for continuity of care (for example, giving a verbal report to the next shift).

It is always better to report something than to risk endangering the person, the agency, and yourself by not reporting it.

Reporting helps your supervisor act accordingly.

E. DOCUMENTING

Documenting, also called *charting*, is the written communication of observations and actions taken in the care of the individual.

1. Significance of Documentation

- A record of what was done, observed, and how the person reacted.
- Used for evaluation by other team members of the care plan.
- Used to clarify complaint issues.

Remember two important phrases:

- "If it wasn't documented, it wasn't done."
- "The job is not over until the paperwork is finished."

> **!** **Always remember that the client record is a legal document.**

2. Documentation Guidelines

Your agency will tell you about policies and procedures you need to know. Some agencies have specific forms you need to use. You may learn specific rules for reporting information and incidents. The following is a list of general guidelines.

- Always use ink.
- Sign all entries with your name and title, if any, and the date and time.
- Make sure writing is legible and neat.
- Use correct spelling, grammar, and punctuation and abbreviations (Refer to the Standardized Medical Abbreviations list on the following pages).
- Never erase or use correction fluid. If you make an error, cross out the incorrect part with one line, write "error" over it, initial it, and rewrite that part.
- Do not skip lines. Draw a line through the blank space of a partially completed line or to the end of a page. This prevents others from recording in a space with your signature.
- Be accurate, concise, and factual. Do not record judgments or interpretations.
- Make entries in a logical and sequential manner.
- Be descriptive. Avoid terms that have more than one meaning.
- Document any changes from normal or changes in the person's condition. Also document that you informed the person's physician or your supervisor as indicated.
- Do not omit any information.
- Try to relate your charting to the objectives/goals on the person's plan. For example, if walking more is a goal, write *"walked 3 times today without assistance from bedroom to kitchen"* instead of *"had a good day today"*.

3. Documenting and Reporting Facts

When you document or report your observations and actions, it is important that you are objective. Write down facts and describe exactly what happened. What exactly did you see or hear? What exactly did the client say? Write down the words that the client said, not what you think he or she meant. Opinions are less useful because you may interpret a situation one way, but another person may have a different opinion.

Example: "*Mrs. Jones said: 'I don't want to eat anything.' She did not touch the chicken sandwich I prepared for lunch; she only drank ice tea."*

Don't try to explain why you think she does not want to eat. Just write what she said and did. When you don't stick to the facts, your opinion may cause a client to lose his or her much-needed services.

4. Documentation Activity

Practice documentation, using the documentation guidelines. Here is an example:

Sara (client) has not been eating much lately so the goal is to increase her intake. During your shift today, she ate all of her lunch.

The documentation may look something like this:

Client Name: Sara Jones

Date/Time	Action/Observation
9/29/05 3:15pm	Sara ate all of her chicken salad sandwich and 1/2 cup jello w/ bananas for lunch. Sara stated she liked the bananas and enjoyed using her good china and having flowers on the table. — Susie Worker

What would your documentation look like in these situations? What would you report? You can use the form on the next page.

- When you arrived at Sara's house today she stated that she had fallen during the night. She is not complaining of pain except for a bruise on her leg.
- While you were washing dishes you broke a plate.
- During your shift Sara had an episode of chest pain. She took a nitroglycerin tablet and the pain went away.

XYZ Agency	
Client Name:	
Date / Time	**Action / Observation**

5. Standardized Medical Abbreviations and Acronyms

Every agency has different needs. For some positions you may have to learn some of these abbreviations. Use this table as a reference.

A	
abd	abdomen
ac	before meals
AD	right ear
ADL	activities of daily living
ad lib	as desired
AM	between 12 midnight & noon
AP	apical pulse
AROM	active range of motion
AS	left ear
ASAP	as soon as possible
ASHD	arteriosclerotic heart disease
as tol	as tolerated
AU	both ears
ax	axillary
B	
bid	two times a day
BM	bowel movement
BP	blood pressure
BRP	bathroom privileges
BS	bowel sounds
C	
c̄	with
CAD	coronary artery disease
Cal	Calorie
cap	Capsule
CBC	complete blood count
cc	cubic centimeter
C & DB	cough and deep breath
CHF	congestive heart failure
Chol	cholesterol
CNS	central nervous system
COPD	chronic obstructive-pulmonary disease
CPR	cardiopulmonary resuscitation
CVA	cerebrovascular accident
D	
dc,d/c	discontinued
dias	diastolic
DM	diabetes mellitus
DOA	dead on arrival
Dx	diagnosis
E	
ECF	extended care facility
ECG, EKG	electrocardiogram
EEG	electroencephalogram
EENT	eyes, ears, nose, & throat
EMG	electromyogram
ER	emergency
F	
FBS	fasting blood sugar
Fe	iron
Fib	fibrillation
ft	feet
Fx	fracture
FWB	full weight bearing
G	
GI	gastrointestinal
gm	gram
gr	grain
gtts	drops
GU	Genitourinary
Gyn	Gynecology

H

H2O	water
H2O2	hydrogen peroxide
hgb	Hemoglobin
hr	Hour
hs	hour of sleep
ht	Height
Hx	History

I

ICU	intensive care unit
I & O	Intake and output
IPPB	intermittent positive pressure breathing device
I/S	instruct and supervise

K

K	potassium

L

lab	laboratory
lb, #	pound
liq	liquid

M

MD	medical doctor
med	medication
mEq	milliequivalents
mg	milligram
MI	myocardial infarction
min	minute
mi	mile
mm	millimeter
MOM	milk of magnesia
MS	multiple sclerosis
MSW	medical social work, or Master of Social Work

N

Na	sodium
Neg	negative
Neuro	neurology
No.#	number
NPO	nothing by mouth
NS	normal saline
nsg.	nursing
N & V	nausea and vomiting
NWB	no weight bearing

O

O2	oxygen
OD	right eye
OR	operating room
ortho	orthopedics
os	oral
OS	left eye
OT	occupational therapy
OU	both eyes
oz	ounce

P

pc	after meals
peri	perineal
PM	after 12 noon
po	by mouth
pre op	preoperative
pm	as necessary
PROM	passive range of motion
pt	patient
PT	physical therapy
PVD	peripheral vascular disease

Q

q	every
qd	everyday
qh	every hour
qid	four times a day
qod	every other day
qt	quart
quad	quadriplegic

R

RBC	red blood count
reg	regular
ROM	range of motion
Rx	prescription

S

s	without
SO	significant other
ST	speech therapy
Stat.	at once/immediately
SQ/subq	subcutaneous
syst	systolic
Sx	symptoms

T

TB	tuberculosis
Tbsp	tablespoon
temp	temperature
TIA	transient ischemic attack
tid	three times a day
TPR	temperature, pulse, respirations
Tx	treatment

U

UA	urinalysis
URI	upper respiratory infection
UTI	urinary tract infection

V

via	by way of
VS	vital signs

W

WBC	white blood count
W/C	wheelchair
wk	week
WNL	within normal limits
wt	weight

Y

yr	year

Symbol

$\dot{T}$	one of something
$\dot{T}\dot{T}$	two of something

Mix and Match Exercise: Medical Abbreviations

1.	a.c.	_____	twice a day
2.	A.M.	_____	before meals
3.	b.i.d.	_____	four times a day
4.	cc	_____	immediately
5.	DC	_____	right eye
6.	gtts	_____	morning
7.	h.s.	_____	cubic centimeter
8.	NPO	_____	every 2 hours
9.	OD	_____	teaspoon
10.	OS	_____	three times a day
11.	OU	_____	every other day
12.	p.c.	_____	as needed
13.	P.M.	_____	drops
14.	PO	_____	discontinue
15.	p.r.n.	_____	every day
16.	q.d.	_____	after meals
17.	q2H	_____	both eyes
18.	q4H	_____	by mouth
19.	q.i.d.	_____	hour of sleep
20.	q.o.d.	_____	left eye
21.	stat	_____	nothing by mouth
22.	t.i.d.	_____	every 4 hours
23.	tsp	_____	afternoon
24.	ml	_____	milligram
25.	mg	_____	grain
26.	gr	_____	milliliter
27.	†	_____	two
28.	††	_____	one

Did you know?

1. Mr. Chang seems different. He normally reads the paper or watches TV; today he just sits quietly.
   a. You ask him how he is feeling.
   b. You don't disturb him.

2. Mrs. Green does not want to eat lunch. You remember that she did not eat lunch the last time you were there.
   a. You are not concerned; sometimes people are not hungry.
   b. You document that she did not eat lunch and also report it to your supervisor.
   c. You document that she did not eat lunch.

3. Mrs. Brown complains she always feels cold.
   a. You write in your notes "*Mrs. Brown stated 'she always feels cold'."*
   b. You write in your notes *"Mrs. Brown is cold."*

4. Mr. Jones did not want to get out of bed.
   a. You write in your notes: *"Mr. Brown stayed in bed; I think he is sick."*
   b. You write in your notes: *"Mr. Brown stayed in bed."*