PRINCIPLES OF CAREGIVING

FUNDAMENTALS

SECTION SEVEN - OBSERVING, REPORTING AND DOCUMENTING

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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 consumers 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
Charting
Documentation
Progress notes
Sign
Reporting
Support plan
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 the consumer and/or family. Since the consumer may even be unaware of changes, it is vitally important for the DCW to communicate with other team members (including the consumer'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 and so 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 consumer 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.

- You may want to 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 the section on Fire, Safety and Emergencies.

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.

- ➢You may ask, “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; 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 consumer may act distant or afraid when family members or visitors are around.

- ➢Ask yourself: Is there someone interacting with the consumer who appears to causing emotional distress? If you notice any signs of drug activity, verbal or physical abusive, 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)

C. CARE PLANS AND SUPPORT PLANS

1. A care or support plan (depending on the agency terminology) is a written plan created to meet the needs of the consumer.
2. The plan is usually created during an in-home assessment of the consumer's situation, the strengths and care being provided by family and friends.
3. The plan defines the needs and objectives/goals for care.
4. The plan lists the actions to be provided by the DCW.
5. 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.**
6. Care/support plans are reviewed by the care team. The DCW working on the case 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 consumer 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, e.g., giving a verbal report to the next shift.

- It is always better to report something than to risk endangering the consumer, 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 consumer.

1. Significance of Documentation

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

Remember two important phrases:

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

Always remember that the consumer 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.

a) Always use ink.
b) Sign all entries with your name and title, if any, and the date and time.
c) Make sure writing is legible and neat.
d) Use correct spelling, grammar, and punctuation and abbreviations (Refer to the Standardized Medical Abbreviations list on the following pages).
e) 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.
f) 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.
g) Be accurate, concise, and factual. Do not record judgments or interpretations.
h) Make entries in a logical and sequential manner.
i) Be descriptive. Avoid terms that have more than one meaning.
j) Document any changes from normal or changes in the consumer's condition. Also document that you informed the consumer's physician or your supervisor as indicated.
k) Do not omit any information.
l) Try to relate your charting to the objectives/goals on the consumer's plan, e.g. if it is walking, "walked 3 times today without assistance from bedroom to kitchen" instead of "had a good day today".

3. Documentation Activity

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

Sara (consumer) 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	Sara ate all of her chicken salad sand-
3:15pm	wich 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.

1. 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.

2. While you were washing dishes you broke a plate.

3. During your shift Sara had an episode of chest pain. She took a nitroglycerin tablet and the pain went away.

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

4. Standardized Medical Abbreviations and Acronyms

Every agency has different needs. For some positions you may have to learn some of these abbreviations. For other positions you may not need to know them. Use this table as a reference.

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

GU	Genitourinary	**N**	
Gyn	Gynecology	Na	sodium
H		Neg	negative
H2O	Water	Neuro	Neurology
H2O2	hydrogen peroxide	No.#	number
hgb	Hemoglobin	NPO	nothing by mouth
hr	Hour	NS	normal saline
hs	hour of sleep	nsg.	Nursing
ht	Height	N & V	nausea and vomiting
Hx	History	NWB	no weight bearing
I			
ICU	intensive care unit		
I & O	Intake and output		
IPPB	intermittent positive pressure breathing device		
I/S	instruct & supervise	**O**	
K		O2	oxygen
K	Potassium	OD	right eye
L		OR	operating room
lab	Laboratory	ortho	orthopedics
lb.#	pound	os	oral
liq	liquid	OS	left eye
M		OT	occupational therapy
MD	medical doctor	OU	both eyes
med	medication	oz	ounce
mEq	milliequivalents	**P**	
mg	milligram	pc	after meals
MI	Myocardial infarction	peri	perineal
min	minute	PM	after 12 noon
mi	mile	po	by mouth
mm	millimeter	pre op	preoperative
MOM	milk of magnesia	pm	as necessary
MS	Multiple sclerosis	PROM	passive range of motion
MSW	medical social work, or Master of Social Work	pt	patient

PT	physical therapy	**T**	
PVD	peripheral vascular disease	TB	Tuberculosis
Q		Tbsp	tablespoon
q	every	temp	temperature
qd	everyday	TIA	transient ischemic attack
qh	every hour	tid	three times a day
qid	four times a day	tid	three times a day
qod	every other day	TPR	temperature, pulse, respirations
qt	quart	Tx	treatment
quad	quadriplegic	**U**	
R		UA	urinalysis
RBC	Red blood count	URI	Upper Respiratory Infection
reg	regular	UTI	Urinary Tract Infection
ROM	range of motion	**V**	
Rx	prescription	via	by way of
S		VS	vital signs
s	without	**W**	
SO	significant other	WBC	white blood count
ST	speech therapy	W/C	wheelchair
Stat.	at once/immediately	wk	week
SQ/subq	subcutaneous	WNL	within normal limits
syst	systolic	wt	weight
Sx	symptoms	**Y**	
		yr	year
ṫ	One		
ṫṫ	two		

Medical Abbreviations

Mix and Match Exercise

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.	T̀	________	two
28.	T̀T̀	________	one