Hartman's
In-Service Education SourceBook Series

The Importance of Observation and Documentation

Hartman

The Importance of

OBSERVATION and DOCUMENTATION

Contributor
Jetta Fuzy, RN, MS
Director of Education & Training
Health Education, Inc.
Fort Lauderdale, Florida

The publisher gratefully acknowledges the contributions of the following individuals who reviewed this material:

Sharon Edwards, RN, MSN, CS
Clinical Nurse Specialist
Superior Home Health Care
Kingsport, Tennessee

Catherine A. Whaley, RN, CRNI
Director of Education
Woodbine Rehabilitation & Healthcare Center
Alexandria, Virginia

Albuquerque, NM

NOTICE TO THE READER

Though the guidelines contained in this text are based on consultations with health care professionals, they should not be considered absolute recommendations. The instructor and readers should follow employer, local, state, and federal guidelines concerning health care practices. These guidelines change, and it is the reader's responsibility to be aware of these changes and of the policies and procedures of her or his health care facility/agency.

The publisher, author, editors, and reviewers cannot accept any responsibility for errors or omissions or for any consequences from application of the information in this book and make no warranty, express or implied, with respect to the contents of this book.

Publisher does not warrant or guarantee any of the products described herein or perform any analysis in connection with any of the product information contained herein.

CREDITS

Contributor: Jetta Fuzy, RN, MS
Development Editor: Celia McIntire
Composition: Tech Reps, inc.
Design: John W. Davis
Illustration: Celia McIntire

ISBN 1-888343-13-3

Table of Contents

FYI

The qualifications for a health care giver include maturity, gentleness, kindness, sensitivity, and a willingness to answer human needs. Health care givers must possess intelligence and observation skills, be physically able to perform the tasks required, and work well under professional supervision. As if that isn't enough, they must be able to document accurately as well!

Documentation is becoming a very vital function of nursing assistants and home health aides. Because aides and assistants spend more time with a resident or client than any other member of the health care team, they have more opportunities to relate to that person and his or her family. It is important that aides communicate their observations to the other members of the health care team. They can best do this through accurate documentation.

Documentation of services can help ensure that the care provided is appropriate and continuous. Documentation is also the basis of the reimbursement system. Because of these reasons, aides and assistants must keep their charting skills accurate. This in-service is a review of previously taught documentation guidelines and information. It is important that your agency's or facility's paperwork be very familiar to your employees. For this reason, you will want to include a review of specific company policies and paperwork as a part of this in-service program.

Every agency and facility has different policies about documentation. Some are simple check-off lists and others have space for writing in sentences. No matter what policies and forms your agency uses, all rules and guidelines in this program will apply.

Other areas of documentation that may be new content include incident reporting, legal aspects of documentation, observation and recording, and a section on abbreviations and commonly misspelled words.

The industry is relying more and more on the skills of the assistant as a vital aspect of the total care for clients. To validate this care and to best utilize the time and talent of nursing assistants, proper writing skills are as important as caregiving skills.

Throughout this in-service, you should emphasize the responsibility of ALL health care givers to carefully and accurately document patient care, patient response, and changes in status.

This in-service can be divided into five sections for teaching purposes:

Definition of Documentation:
Learning Objectives 1, 2

Reasons for Documentation:
Learning Objectives 3, 4

How to Observe Accurately:
Learning Objectives 5, 6

How to Document Accurately:
Learning Objectives 7, 8, 9, 10

Practice Documenting:
Learning Objectives 2, 7, 10

Introduction and Assessment

Estimated Time:	10-15 minutes
Tools:	Handout Intro-1 Assessment A Handout Intro-2 Assessment A Answer Key Handout Intro-3 Note-Taking Worksheet Handout Intro-4 Key Terms

Learning Activity:	**Assessment**
Distribute Handout Intro-1 Assessment A	Allow participants enough time to finish the assessment. This is a good way for them to find out how much they already know. Advise them that this is not a pass or fail test, but a tool to help them evaluate their knowledge. You may choose either to go over the answers as a lead-in to discussion or repeat the same test at the end of the in-service. However, Handout Closing-1 Assessment B (pg. 68) can be used as a post-test in place of this one at the end of the in-service.
Distribute Handout Intro-3 Note-Taking Worksheet	Encourage participants to take notes during the in-service to help them organize and remember the information.
Distribute Handout Intro-4 Key Terms	Review the key terms as necessary.

Assessment A

Name: _____
Date: _____

Mark each statement either T (True) or F (False).

1. _____ The medical record is a legal document.

2. _____ You can document care given by a friend if that person is trustworthy.

3. _____ Documentation is a communication tool.

4. _____ The only source of information that can be documented is what you observe.

5. _____ Documentation is not actual proof of something seen or heard.

6. _____ Leaving out information from the medical record is as much of a problem in documentation as writing inaccurate information.

7. _____ “Reimbursement” is payment to the health care agency or facility for the cost of caring for a client or resident.

8. _____ You should carry a dictionary or keep one handy.

9. _____ Symptoms are objective information, or what you can observe about a person in your care.

10. _____ A good example of a sign is vomiting.

11. _____ Daily documentation should reflect the client's or resident's Activities of Daily Living and mental state.

12. _____ When documenting mobility and function, you do not have to include the use of assistive devices, such as walkers and canes.

13. _____ Nutrition level is not an important part of observation.

14. _____ Incidents are accidents.

15. _____ Incidents are documented on the medical record.

16. _____ Words such as "good" or "normal" are excellent words to use when documenting.

17. _____ If you are unable to reach the supervisor, there is no need to document your attempts.

18. _____ ANTEBIOTIC is a correct spelling.

19. _____ COMMODE is a correct spelling.

Which of the following are correct (T) abbreviations and which are incorrect (F) abbreviations?

20. _____ CHF stands for Cardiac Heart Failure.

21. _____ BRP stands for Bath Room Privileges.

22. _____ FBS stands for Fasting Blood Sugar.

23. _____ ADL stands for Activities the Doctor Likes.

24. _____ O stands for Oxygen.

25. _____ SOB stands for Sometimes Out of Bed.

Assessment A Answer Key

1. **True** A medical record may be used in court. (Learning Objective 3, 4)
2. **False** Health caregiver should only document care provided by self. (Learning Objective 3)
3. **True** (Learning Objective 1, 4)
4. **False** Other sources of documentation include what you do and what information the client/resident or family members give. (Learning Objective 1)
5. **False** Documentation is proof or support of something seen, heard, or done. (Learning Objective 1, 3)
6. **True** For example, failing to note potential for self-injury. (Learning Objective 3)
7. **True** (Learning Objective 3)
8. **True** (Learning Objective 8)
9. **False** Symptoms are subjective information, or what the client/resident tells you. (Learning Objective 5)
10. **True** (Learning Objective 5)
11. **True** (Learning Objective 6)
12. **False** You must include any information that relates to ambulation and walking, including the use of walkers, canes, wheelchairs, etc. (Learning Objective 6)
13. **False** Nutrition is one of the thirteen basic observations. (Learning Objective 6)
14. **True** (Learning Objective 10)
15. **False** Incidents are only documented on incident forms. (Learning Objective 10)
16. **False** Avoid such nonspecific words. (Learning Objective 7)
17. **False** All attempts to reach supervisors must be carefully documented. If you cannot reach the supervisor, you should leave a message and document that you did so. (Learning Objective 7)
18. **False** ANTIBIOTIC is correct. (Learning Objective 8)