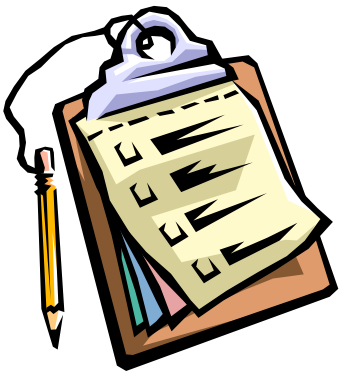
The Inservice Club for Nursing Assistants

IN THE KNOW

A Communications Skills Module: Reporting & Documenting Client Care

Instructions for the Learner



We hope you enjoy this Inservice, prepared especially for nursing assistants like you. You work very hard, and we appreciate the effort you make to complete these educational materials. It shows your desire to continue learning and growing in your profession!

After finishing this inservice, you will be able to:

- Name at least three purposes of clinical documentation.
- Describe the difference between objective and subjective observations.
- Discuss the five rules of clinical documentation.
- Describe the purpose of an incident report.
- Complete your documentation according to the guidelines presented in this inservice and the policies of your workplace.

<u>If you are studying the inservice on your own, please:</u>

- Read through all the attached materials. You may find it useful to have a highlighting marker nearby as you read. Highlight any information that is new to you or that you feel is especially important.
- If you have questions about anything you read, please ask _____.
- Take the quiz. Think about each statement and circle the best answer.
- Check with your supervisor for the right answers. You pass the quiz with at least eight correct answers! Print your name, write in the date, and then sign your name.
- Keep the inservice information for yourself, and turn in the quiz page to _____ no later than _____.
- Show your Inservice Club Membership Card to _____ so that it can be initialed.

THANK YOU!

The Inservice Club for Nursing Assistants

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Reporting & Documenting Your Client Care

Do you work in a nursing facility where you give client care to as many as twenty residents during a shift? Or, maybe you work in a hospital, caring for eight to ten sick patients a day? Perhaps you are a home health aide, providing care to only one client at a time?

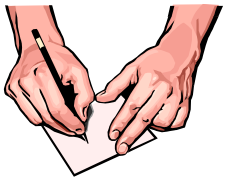
No matter *where* you work, there is one thing about the job of a nursing assistant that always stays the same: you are responsible for reporting and documenting information about your clients.

What is important to remember about client care documentation?

- Each of your clients has a medical chart that acts as a permanent legal record of the client's care.
- You serve as the "eyes and ears" of the rest of the health care team. Your observations help the team make the necessary changes in each client's care plan.
- The information you report—either by *telling someone* or by *writing it down*—affects the care your clients receive.

At most health care organizations, each client's medical information is collected in a folder or binder. You may hear this document called a:

- Clinical record.
- Chart.
- Medical record.



- Supervisors check the quality of your documentation when completing annual performance reviews. So, reporting about your clients gives you a chance to demonstrate your professionalism.
- All client care reports and documents must be kept confidential.

Keep reading to learn more about reporting and documenting your client care!

Why Is Clinical Documentation Important?

Most health care workers are required to write about their daily work with clients. Clinical documentation is important because it:

- Allows members of the health care team to communicate with each other so that they can work together to keep clients safe and healthy.
- Serves as legal evidence that you have performed your job as ordered.
- Provides a place to record changes in the client's care plan.
- Helps health care organizations meet the requirements for licensure and/or accreditation.
- Keeps a record of the services provided to each client so that your workplace may receive payment.

Remember…

Your documentation may be read by a number of different people, including:

- Your coworkers and supervisors
- State and/or JCAHO surveyors
- Quality improvement personnel
- Medicare and insurance company reviewers
- Researchers
- Lawyers and judges

What Should You Include In Your Report?

Whether you write it down or tell someone, your report should include:

Observations

- Observations are the facts and events that you notice as you go about your daily work. (See page three for more about making observations.)

Daily Measurements

- You may be ordered to record your client's:
  - Vital signs.
  - Weight
  - Intake and Output
  - Blood sugar level

Safety Issues

- This includes measures you took to ensure a client's safety and any concerns you have about possible safety hazards in the client's environment.

Client Statements & Complaints

- Document—in their *exact* words—any pertinent statements your clients make about how they are feeling. This may include statements about pain, appetite or emotions.
- Be sure to report complaints. (Again, use the client's exact words.) Complaints help your workplace improve client care and/or find new ways to meet a client's needs.

Unusual Events

- Report anything out of the ordinary that happens while you are with a client. For example, be sure to document if a client refuses care or if the heat in the client's room doesn't work. (Notify your supervisor as soon as possible, too.)

Making Observations

- When you observe your clients, you take note of *facts* and *events*. Observations may be *subjective* or *objective.*
  - If a client *tells* you something, it is subjective information and should be written inside quotation marks. (For example, Mrs. Smith states, *"I feel like I'm getting a cold."*)
  - Objective observations include things you can see, hear, smell and feel.




- ***With your eyes, you can see a client's:***
  - Daily activities such as eating, drinking, ambulating, dressing and toileting.
  - Body posture.
  - Skin color, bruising or swelling.
  - Breathing pattern.
  - Bowel movement (including the color, amount and consistency).
  - Urine (including color, amount and frequency).
  - Facial expressions (such as smiling, frowning, grimacing or crying).

- ***With your ears, you can hear a client's:***
  - Raspy breathing.
  - Coughing.
  - Sneezing.
  - Crying or moaning.
  - Blood pressure.

- ***With your nose, you can smell a client's:***
  - Breath.
  - Body odor.
  - Urine.
  - Bowel movement.
  - Vomit.
  - Environment (such as an unusual chemical odor or gas leak).

- ***With your fingers, you can feel a client's:***
  - Skin temperature.
  - Skin texture.
  - Pulse.

Remember: Making observations involves using four senses: sight, hearing, smell and touch. State *objective* observations as facts and write *subjective* observations as statements in quotation marks.

Time to Laugh!

Roberta works in a nursing home. Her clients were sitting around, telling her how they were feeling, and she was writing down their subjective statements.

"*My arms are so weak I can hardly lift this cup of coffee*," said Mr. Smith.

"*Well, my cataracts are so bad I can't even see my coffee*," said Mrs. Baxter.

"*You know, I can't turn my head because of the arthritis in my neck*," said Mr. Thomas.

"*And, my blood pressure pills are making me dizzy*," said Mrs. Wilson.

"*I guess that's the price we pay for getting old*," said Mr. Tucker.

After a short moment of silence, Mrs. Monroe said, "*Well...it's not that bad. At least we can all still drive!*"

History of Clinical Documentation

- Years ago, charting about clients consisted of short (and rather meaningless) observations such as: *"The patient ate well."* or *"The patient slept well."* Doctors did not expect to read anything of importance in notes written by nurses or nursing assistants.
- In the 1800's, a British nurse named Florence Nightingale developed theories about nursing documentation. She believed that nurses should chart their observations about patients in a clear, *organized* fashion.

- More than 100 years went by before nurses began to develop their own documentation systems—based on *nursing diagnoses*.

The charting done by nursing paraprofessionals like yourself is vital to client care. You spend a lot of time with clients and may be the first person to notice changes in a client's condition. By documenting your observations, you help your clients receive the best care possible.

Doctors Say the Funniest Things!

Can you believe that the following statements were written by physicians in actual medical records? Take a minute to chuckle…

- *"By the time he was admitted, his rapid heart had stopped and he was feeling better."*
- *"Patient has chest pain if she lies on her left side for over a year."*
- *"The patient had waffles for breakfast and anorexia for lunch."*
- *"Her skin was moist and dry."*
- *"When she fainted, her eyes rolled around the room."*
- *"She stated that she had been constipated for most of her life until 1989 when she got a divorce."*
- *"Bleeding started in the rectal area and continued all the way to Los Angeles."*
- *"He is numb from his toes down."*
- *"The patient refused an autopsy."*
- *"The patient has no past history of suicide."*

Different Charting Systems

There are a number of different methods for documenting client care. A few of these systems include:

- **Narrative**. This type of charting consists of progress notes that create a "story" about a client's care.
- **Problem Oriented**. The client's plan of care is divided into specific problems. This makes it easy to follow the client's progress in each area—without having to read the whole chart.
- **SOAP**. This style of charting involves writing about **s**ubjective observations, **o**bjective observations, an **a**ssessment of the client's problems and the **p**lan for taking care of those problems.

Each workplace has its own system for documentation. Be sure you know the correct method and forms to use when documenting your client care.

Rule # 1:
Make Sure Your Documentation Is Complete

Complete documentation is thorough and follows your workplace policies. In general, your documentation will be ***complete*** if you include:

- The correct date and time.
- The client's correct name.
- The tasks you perform with each client and how the client responds to your care.
- Any changes you notice in a client's condition.
- Any care that was refused by the client.
- Any phone calls or oral reports you made about the client to a supervisor. (Include the supervisor's name.)
- Your signature and job title.
- Note: Check with your supervisor about how to complete the specific forms used in your workplace.

How would you feel about signing your name if you were these real life doctors?

A *cardiologist* named Dr. *Hart*
A *dermatologist* named Dr. *Rash*
A *family physician* named Dr. *Killer*
A *psychiatrist* named Dr. *Nutt*
An *orthopedic physician* named Dr. *Bones*
A *surgeon* named Dr. *Butcher*

Rule # 2:
Keep Your Documentation Consistent

Documentation is consistent when it remains true to:

- The client's care plan.
- Physician and nursing orders.
- The observations that your coworkers have made about the same client.
- Your workplace policies.

Your documentation will be ***consistent*** if you:

- Use workplace-approved medical terms and abbreviations.
- Perform your care according to each client's care plan. If you are unable to follow the care plan on a particular day, document the reason why.

- Tell your supervisor right away if you notice changes in a client's condition so that your observations can be shared with other members of the health care team. This keeps your coworkers from documenting incorrect information. For example, you take your client's BP and it's suddenly very high. If you don't inform the nurse, she may document that the client's vital signs are normal. This can cause confusion and have a negative effect on client care.
- If you make home health visits, be sure your documentation matches the visit frequency ordered by the physician.

Rule # 3:
Check That Your Documentation Is Legible

Documentation is legible when it can be easily read. Your documentation will be ***legible*** if you:

- Keep in mind that one of the purposes of documentation is to communicate with other members of the health care team. (If no one but you can read your handwriting, your documentation won't communicate anything to anybody!)
- Use a black or blue ballpoint pen. (The ink from felt tip pens tends to "bleed".)
- Watch your handwriting...messy documentation could come back to haunt you in a lawsuit.
- Remember that sloppy handwriting takes extra time to read and can lead to mistakes in client care.
- If your cursive handwriting tends to be hard to read, try printing instead.

Flow sheets are often used as a quick way to document vital signs, weights and other tasks. If you use flow sheets, make sure they are <u>legible</u>. Here are a couple of tips:

- Fill out the flow sheet properly. For example, do you circle numbers or words on the flow sheet? Or, are you supposed to make marks like X's or checkmarks?
- Don't try to cram long narrative documentation onto a flow sheet.

Rule # 4:
Make Sure Your Documentation Is Accurate

Documentation is accurate when it is true. Your documentation will be ***accurate*** if you:

- Use appropriate medical terms and abbreviations that have been approved by your workplace.
- Use correct spelling and proper English.
- Double check that you've written down the correct client name (and ID number, if required).
- Handle errors correctly. (See page 11.)
- Avoid adding information after the fact.
- Record only the facts...*not* your opinions about those facts. For example, if your client seems dizzy and confused, don't write what you *guess* to be true, like *"Client acts like she's on drugs"*. Instead, stick to the facts, like *"Client is unable to stand up without assistance and called me by her mother's name several times"*.

- Record what a client tells you by quoting his <u>exact</u> words. For example: If your client says, *"I want my daughter to visit"*, <u>don't</u> put what he said in your own words such as *"client misses his daughter"*. That's not really what he said!

Remember...when you sign your name to your documentation or put your initials on a flow sheet, you become <u>responsible</u> for the accuracy of that information.

Rule # 5:
Finish Your Documentation On Time

Documenting on time means writing information down as it happens and turning in your paperwork when it is due. Your documentation will be ***on time*** if you:

- Write information down immediately. For example, if you take a client's vital signs, document them right away. Don't wait until you finish your care and leave the room. The longer you wait, the more likely you are to forget some of the details.
- Be sure you make note of exact times on your documentation. Don't guess at the time or put a general time frame like *"Day Shift"*.
- Note the time of your arrival and your departure from each client's home (if you make home health visits).

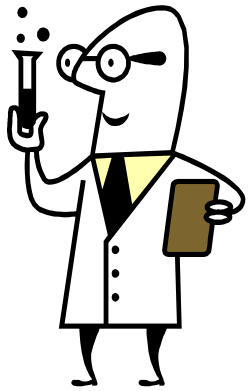
- Use the proper time format according to your workplace policy. For example, some health care organizations use a twelve hour clock, noting whether it's AM or PM. Others use a twenty-four hour clock—also called military time. Using military time, 6:00PM is written as 1800.
- Most home health aides are required to document their care on visit notes. If you care for clients in their homes, be sure to complete your visit notes at the time of each home visit. Don't wait until the end of the day to fill out visit notes on all your clients. Be sure to meet the deadlines for turning in your visit notes at the office. (Remember: completing visit notes on time helps you and your workplace get paid!)

Time To Laugh

A medical school professor was teaching a class called "Making Observations". He took out a jar of yellow-colored liquid. *"This,"* he explained, *"is urine. To be a good doctor, you have to be observant to color, smell, sight and taste."*

After saying this, he dipped his finger into the jar, then put it into his mouth. His medical students watched—some were amazed, others were disgusted. The professor passed the jar to the class and said, *"Now, you do exactly what I did."*

Since they wanted to impress the professor, each student took a turn. They dipped one finger into the jar and then put it into their mouths.



After the last student was done, the teacher shook his head. He said, "*Well, you all failed that test. If any of you had been observant, you would have noticed that I put my **second** finger into the jar and my **third** finger into my mouth!"*

Acute Care

Forms Commonly Used in Acute Care:

- **Care plans** or **critical pathways** *(used to outline the client's needs).*
- **The Kardex** *(often used to easily document patient activities, treatments and medications).*
- **Progress notes** *(for documenting about changes in the client's condition).*
- **Flow sheets** or **graphic forms** *(for tracking vital signs and weights).*

Special Tips For Acute Care Documentation:

- Keep in mind that patients in acute care settings tend to be quite sick. If you are ordered to document their vital signs every four hours, it's important to take their vitals—and document the results—on time.
- Remember that sick patients can become sicker in a matter of minutes. And, as they get better, they can be discharged on short notice. It's very important to complete your documentation in a timely fashion.

Home Health Care

Forms Commonly Used in Home Health Care:

- **Plan of care** *(may be known as a "486" which is a special Medicare/Medicaid care plan).*
- **Home health aide care plan** *(used to outline the assignment for each client).*
- **Daily** or **weekly visit note** *(for documenting the care you give each time you visit a client).*

Special Tips For Home Health Documentation:

- Home health clients whose care is paid for by Medicare must be homebound—and must need help with bathing—to receive the services of a home health aide. Your documentation should show that your client meets these requirements. However, if your client isn't home or has already bathed when you arrive for your visit, document the reason and let your supervisor know right away.
- Take extra care to keep your documentation confidential—especially in the client's home (where friends or neighbors might see it) and in your car.

Long Term Care

Forms Commonly Used in Long Term Care:

- **Minimum Data Set** *(called MDS for short; it's used to evaluate the care of each resident).*
- **ADL checklists** or **flow sheets** *(used to track the daily care given to each resident).*

Special Tips For LTC Documentation:

- Residents of long term care facilities may stay for weeks, months or even years. Some of them may need skilled care (which requires *more frequent* documentation). Others receive a lower level of care (which requires *less frequent* documentation).
- A resident's condition may change slowly over time. Even though your clients may seem the same day after day, don't forget to watch out for—and document—physical and mental changes.
- Keep in mind that most LTC facilities are required to maintain a record of visits and phone calls from family or friends. (The facility may even face a fine if it doesn't comply!) You may be asked to help keep track of your client's visitors and calls.

Legal Issues

Poor documentation can cause a number of legal problems—especially if a client's chart ends up in the hands of a lawyer.

- It may look like you gave *poor care*. For example, let's say you remember turning your client every two hours as ordered, but you didn't write it down *every* time. A lawyer might say that it's *your* fault the client developed an infected bed sore.
- It may also look like you neglected specific orders. For example, if you are ordered to take a client's pulse, but you forgot to write it down, you could be accused of neglecting an order and causing harm to the client.

Poor documentation can cause your workplace to be denied payment for the services you provided to your clients.

- For example, let's say you made a home health visit but failed to turn in your visit note. Your workplace could be accused of fraud—even though you made the visit!

Regulations regarding how to properly document client care come from:

- State Boards of Nursing
- The American Nurses Association
- JCAHO
- HCFA (Medicare and Medicaid)
- Workplace policies and procedures.

A Special Word on Incident Reports

An <u>incident</u> is an unexpected event that often involves an accident or an injury. The injured person may be an employee, a family member or a client. An <u>incident report</u> is a special form on which you describe the event. For example, you need to complete an incident report if:

- You hurt your back while transferring a client.
- You witness a client falling down while getting out of bed.
- You see a family member trip on the stairs in your facility.

Incident reports:

- Do <u>not</u> become part of a client's chart.
- Let the managers at your workplace know about the problem so that similar incidents can be prevented in the future.
- Warn your administrator that there may be potential legal problems (if a client or family member decides to sue).
- Should only be completed by people who actually *witness* an incident. If more than one person witness the incident, each person should complete a *separate* report.
- Should be filled out as soon after the incident as possible so the memory is fresh.

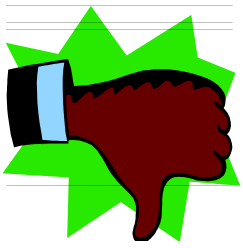
If a client is injured in your presence, be sure to document the facts about the situation in your regular daily paperwork. However, do *not* mention an incident <u>report</u>.

For example, <u>don't</u> write:*"I'm going to fill out an incident report because my client fell down."*

When Documenting, DO:

- Stick to the facts—because facts speak for themselves. (No one can argue with the facts, but they *can* argue with your opinions!)
- Draw lines through unused spaces on a form so they can't be filled in later.
- Remain brief and to the point. You don't need to write a "book" about your clients!
- Be specific! For example, it's not very helpful to write *"client ate well"*. Writing something like *"client ate 75% of lunch tray"* is much better.
- Avoid documenting the same information about a client day after day. (Doing this makes it seem like you aren't really paying attention to your client.) Observe each client carefully and document even small changes.
- If you document directly in clients' charts, make sure you have the right one before you begin to write in it.
- Include each client's full name in your documentation since there may be two clients with the same last name.
- If you document a change in a client's condition, be sure to write what you did about it. For example, if you document *"Mr. Johnson gained 4 pounds since yesterday"*, you should also document that you notified your supervisor. You might write *"Called Jane Doe, RN about weight gain. She said she will talk to doctor."*
- If you leave a voicemail message for a supervisor, document the time, date, person and telephone number you called. This proves that you did your part.

When Documenting, DON'T:



- Criticize the care given by any of your coworkers. Avoid writing about workplace problems like staffing shortages, too.
- Chart for someone else or write down what someone else tells you about a client.
- Document a task that you did not do!
- Write with a pencil...always use ink.
- Use two different colors of ink for the same entry. Someone might think you came back later to correct your initial charting.
- Use language that sounds like you have negative feelings about a client. For example, instead of writing *"client is drunk"*, stick to the facts by writing *"client's breath smells of alcohol and he is slurring his words"*.
- Remove pages from a client's medical record. Each page is a permanent, legal document.
- Mention the name of one client in another client's chart.
- Document your client care ahead of time—even if it never seems to change from day to day.

How To Handle Errors

- If you left out important information, call your supervisor as soon as possible. Follow your workplace policy for charting late information.
- Never correct someone else's charting error. Instead, tell that person that you noticed a mistake in their documentation.
- Never try to *erase* an error in your documentation. Using "White-Out" is also against the rules.
- Follow your workplace policy for correcting an error in your charting. Usually, this involves drawing one line through the error and initialing it. Write *"mistaken entry"* and your initials next to it. (Note: Documenting "mistaken entry" is better than writing "error" since someone might think you made an error in *care*—not just in documentation.)

Making up your own abbreviations can lead to serious errors. For example, these two abbreviations were found in actual medical records. Can <u>you</u> figure out what they mean?

1. **THBNCS** yesterday. 2. The client drank 6 ounces **PWISOTF**.

*1. **T**here **h**ave **b**een **n**o **c**hanges **s**ince yesterday. 2. The client drank 6 ounces **p**lus **w**hat **I s**pilled **o**n **t**he **f**loor.*

Reporting Client Care

- You may be responsible for giving an oral report about a client to your coworkers. This report may be one-on-one with another person or in a group setting such as a team meeting or client care conference.

- Some health care organizations use tape recorders or voice mail systems for reporting client care.
- Oral reports should be given in a professional manner according to your workplace policy. For example, it's not appropriate to tell your supervisor about a client's problem while she's on the phone or is dashing off to eat lunch. She might forget what you told her—and client care could suffer.

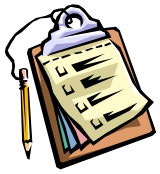
You've probably heard this old saying:

If you didn't write it down, you didn't do it!

This is especially true for health care workers. When medical records are reviewed—by supervisors, surveyors or attorneys—the only information that counts is what is written in the chart. It's too late to say, *"Oh, I forgot to write that down...but I did it!"* The only acceptable proof that you performed your client care as ordered is to document it as it is done. Oral reports are not a substitute for writing information down.

The Inservice Club for Nursing Assistants

Are You "In the Know" About Documentation?



Circle the best choice and then check your answers with your supervisor!

1. Which of the following is an *objective* observation?

A. Mr. Smith seems grumpy in the mornings.
B. Mr. Smith is thirsty all the time.
C. Mr. Smith looks tired today.
D. Mr. Smith has a red rash on his left arm.

2. TRUE or FALSE

A client's medical chart is a permanent, legal document.

3. TRUE or FALSE

If your handwriting is messy, it's okay to have a coworker do your charting for you.

4. To be consistent, your documentation should:

A. Be true to the client's care plan.
B. Include the same information your wrote yesterday.
C. Be as short as possible.
D. Include three subjective statements.

5. An incident report:

A. Is only completed when a client is injured.
B. Does not become part of the client's medical record.
C. Should be signed by all witnesses.
D. Gives a client permission to sue your workplace.

6. TRUE or FALSE

Subjective observations are things you can see, hear, smell or feel.

7. TRUE or FALSE

It's okay to erase errors in a client's chart.

8. TRUE or FALSE

You should sign your client care documentation with your name *and* title.

9. TRUE or FALSE

If you notice a serious change in your client's condition, you should document the problem with red ink.

10. TRUE or FALSE

If your client care isn't documented, a lawyer could accuse you of not providing the care.

EMPLOYEE NAME_____ DATE_____

I understand the information presented in this inservice. I have completed this inservice and answered at least eight of the test questions correctly.

Employee Signature_____ Inservice Credit: 1 hour

Supervisor Signature_____ Self Study _____
File completed test in employee's personnel file. Group Study _____