Reporting and Recording

Bathing, feeding, repositioning, toileting, treatments...these are the types of caregiving activities that probably come to mind when you think about the important things you do during the course of your day. And certainly, these direct care activities are important and essential. Yet, there are some "behind the scenes" activities that can make a significant difference to residents.

Reporting and recording are examples of activities that are not direct "hands-on" tasks, but are very important to residents' care. **Reporting** is the verbal communication of what you have done and observed. **Recording,** or charting, is the written communication of your actions and observations.

The Skill of Observing

Ask someone to stand near you as you try this little experiment.

Close your eyes and without opening them describe to the person the items that are in the room where you now are.

How well did you do?

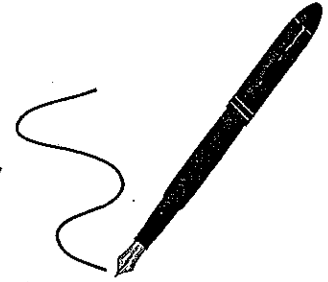
If you're like most people, you may not be able to recall the name of the waiter who served you after you leave a restaurant or remember the model car your friend has, despite having driven in it several times. We receive a considerable amount of information through our senses but often don't absorb and retain much of it.

Seeing or hearing isn't the same as observing. *When you observe, you notice and pay careful attention.* Your senses are alert and absorb the messages they receive.

Observation is an important skill for you to develop. Because you provide direct care and see residents more closely and regularly than other members of the health care team, you are in an ideal position to note changes and problems early. By paying attention to what you see, hear, touch, and smell as you provide care—in other words, by observing—you help residents to obtain the care they need and avoid complications. Of course, your observations have little value if nothing is done about them, so you need to properly report and record them.

Describe signs and symptoms in as much detail as possible

Why Document?



- **To coordinate care** Recording the care you give allows other members of the health care team to know what you did and how the resident reacted. This can help caregivers to understand techniques that work best for a resident and the resident's needs.
- **To give evidence of the care given** When you chart there is written proof of the care you have given. This is particularly important if you are not available to verbally describe your actions or if the care you have given needs to be proven at a later date.
- **To obtain payment.** In order to get reimbursement from Medicaid and Medicare, the facility needs to show proof of the care given.
- **To protect the facility** The resident's record is a legal document that can be used in a court of law. Your documentation can prove that you did properly provide care.
- **To assess quality** The facility can evaluate its action and find areas that may need improvement by reviewing documentation. This enable the facility to continuously improve the quality of services given to residents.

Observations to Report and Record

You make many observations during the average day—many more than you probably realize. Some of these are not important but others can make a big difference to residents' care and to the smooth functioning of the nursing unit. Let's review some ol the major observations that are important to report and/or record.

Signs and Symptoms

Your close involvement with residents enables you to be able to detect signs and symptoms. A *sign* is something that you can see or measure, such as a fever or a bruise. A *symptom* is something that the resident describes to you, such as pain or dizziness.

The figure on page 4 lists some of the signs and symptoms that you should report.

When reporting a sign or symptom describe it in as much detail as possible. Some aspects to note include:

- how long it has been present
- the resident's description
- characteristics, such as "bluish-black area 3 inches round on right elbow", "constant coughing that produces thick yellow mucus", "dark amber urine with strong odor", "becomes short of breath and pale when walking from bed to bathroom", "cries in pain when left hip is touched"
- what caused it
- how it affects the resident (ability of resident to participate in self-care, mental status, etc.)
- what relieves it

It also could be useful to obtain vital signs when new signs and symptoms are present.

Report signs and symptoms as soon as you detect them.

continued on page 5

Signs and Symptoms to Report

Fatigue

Inability to arouse
New hair loss
Excessively dry scalp
Facial pain or numbness
Swollen eyelids
Headaches
Reduced vision
Ringing in ears
Reduced hearing
Crack in corner of mouth
White patches on tongue
Drooling
Poor fitting dentures
Stiff neck
Shortness of breath
Wheezing
Vomiting
Irregular pulse
Heartburn
Lump in breast
Abdominal bulge
Blood in stool
Vaginal bleeding
Swollen, painful scrotum
Uneven limbs
Enlarged veins
Discolored areas
Red areas
Weight loss or gain
Cuts

Change in mental status
Head lice
Lesions on scalp
Drooping of eyelids
Red or pink eyes
Vision changes
Eye pain
Ear wax
Nosebleed
Blue lips
Slurred speech
Unusual breath odor
Loose teeth
Sore throat
Difficulty breathing
Gurgling sounds
Cough
Chest pain
Rash
Nipple discharge
Diarrhea
Worms in stool
Discharge
Painful joints
Cramps
Cold extremities
Numbness
Pain
Changes in vital signs
Bruises

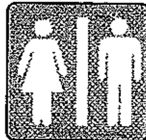
New complaints

Be familiar with the forms that your facility uses for documenting care and use them correctly.

Activities of Daily Living

As routine as they may seem, activities such as feeding, toileting, bathing, and moving residents yield much information about the status of residents. Many facilities have special tools on which this information is documented, such as ADL (Activities of Daily Living) forms. Some consideration when recording ADLs include:

Diet: Pay attention to the resident's meal intake and record the percentage that has been eaten. If the intake has been poor, describe this in as much detail as possible. (For example, *ate only dessert and bread.*)

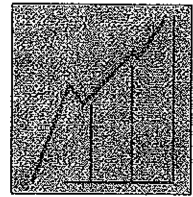


Toileting: Record the number of bowel movements. Describe any unusual elimination patterns, such as diarrhea, straining to pass stool, unusually frequent voiding, or difficulty voiding. If intake and output are being recorded, measure these carefully.

Bathing/Grooming: Indicate they type of bath the resident received, the amount of assistance provided, and any unusual findings. Note if the resident required more or less assistance than usual.

Exercise: Record the resident's physical activity, including times out of bed and how (e.g., wheelchair, geri-chair). Describe ambulation patterns (e.g., walked to lobby, walks only from bed to chair, uses walker). Make notes of the times you provided or assisted with range of motion exercises, or times that you turned and repositioned the resident.

Vital Signs and Weights



Know the resident's schedule for having vital signs and weights taken. Record vital signs as soon as possible after you have taken them. When you record them, go back and look at the previous vital signs. If there are any changes (e.g., weight loss or gain, pulse or BP that is at least 10 points different from the last time) or abnormalities (e.g., irregular pulse, shallow respirations) report this in addition to recording it.

Unusual Events

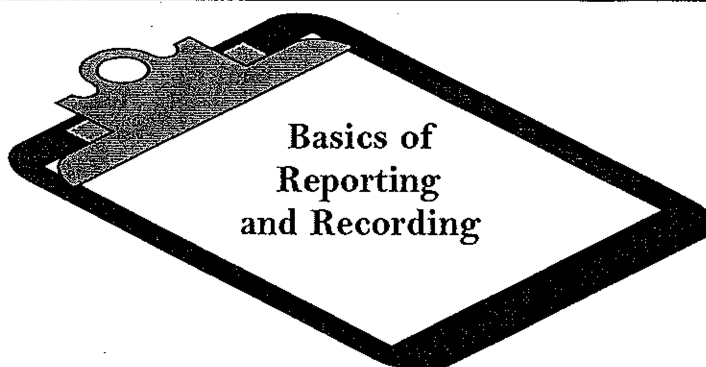
Promptly report anything that happens out of the ordinary. This includes:

- falls, injuries
- complaints
- arguing between residents, residents and visitors, or residents and staff
- unlawful activity
- damaged or lost property
- suspected or actual abuse

Equipment and Environment

Reporting and recording problems and needs related to equipment and the environment are important, too. Report problems such as a leaking faucet, broken icemaker, soiled curtain, chipped plaster, and burned out light. Also, promptly report insect or rodent citing, unusual odors, and other environmental problems.

Your actions in communicating problems and needs can make a significant difference in assuring residents get the care they need and preventing complications. Page 6 provides some general guidelines to help you in reporting and recording.



- Know your responsibilities for reporting and recording including the nurse to whom you are responsible for reporting and the forms on which you are to record.

- Write neatly and legibly with a black pen. Include the date and time for all entries. Sign the entries with your full signature and title.

- Report all unusual findings or new signs and symptoms immediately upon detecting them.

- Record after you have provided care, not before.

- Do not chart or sign-off care or procedures you haven't done.

- Be brief, accurate, and specific.

- Be objective. Do not chart your opinions or criticisms in the resident's record.

- If you chart something that the resident said, use quotation marks. For example, *Resident stated "I fell in the bathroom last night."*

- Use correct spelling and accepted abbreviations.

- Do not remove parts of the resident's record or scratch out or "white-out" entries. If you make an error draw one line through and write *mistaken entry* and your initials. Report your error to the nurse.

- Respect residents' confidentiality by not leaving the chart where others may read it and by not discussing your observations in areas where persons other than caregivers can hear.

- Do not chart for coworkers.

- Remember that the resident's record is a legal document.

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Reporting and Recording Post Test

Name: ______________________ Date: ______________________

1. Observing means to:
   a. see and hear
   b. document
   c. notice and pay attention
   d. record and report

2. You can sign off the care a coworker has given if it is routine and not a treatment.
   a. true
   b. false

3. A CNAs documentation cannot be used in a court of law.
   a. true
   b. false

4. You weigh Ms. Jones and you notice that her weight is 140 lbs. this week but was 132 lbs. last week.
   a. You should report this to the nurse.
   b. You should not report this because weight gains do not need to be reported.

5. You didn't have time to do Ms. Jones' shower today, so:
   a. You sign for having given the shower because you will do it tomorrow.
   b. You leave it blank.
   c. You sign your initials and circle them and you make the nurse aware so she can further document the reason in the resident's medical record.

6. It is acceptable to use "white out" in a resident medical record.
   a. true
   b. false

List 4 points to remember about reporting and recording:

7. ____
8. ____
9. ____
10. ____