Observing, Reporting, & Recording

Lesson Plan

To use this lesson for self-study, the learner should read the material, do the activity, and take the test. For group study, the leader may give each learner a copy of the Learner's Guide and follow this plan to conduct the lesson. You may copy certificates for everyone who completes the lesson and passes the test. ***Approximate time: One hour.***

Objectives

At the conclusion of this lesson, participants will be able to:

1. Explain the importance of observing, reporting and recording.
2. Identify what observations need to be reported and recorded.
3. Describe appropriate reporting and recording procedures.
4. Maintain complete and accurate records.

Preparation

1. Gather a collection of familiar items, such as a stethoscope, a book, a dish, silverware, a stuffed animal or small pillow, loose change, a ball of yarn, marbles or small balls of different colors, or whatever is handy (be imaginative).
2. Purchase small prizes to distribute, such as candy bars or movie tickets.

Activity

1. Give each participant a copy of the page entitled "Learning Activity: Observation Skills." Ask them to cover the questions with a sheet of paper, then look at the picture for one minute or less, and then cover the picture with a piece of paper and try to answer the questions.
2. As an alternate activity, lay the collection of familiar objects you gathered earlier on a table and cover them with a sheet. Give your participants a piece of paper and remove the sheet. Let them look at the table for a minute or less, and then cover the objects. Ask them to list everything they observed—the objects' names, how many, color, texture, shape, and so on.
3. With either activity, see how well participants did by uncovering the picture or the objects and comparing their results. Give small prizes for the most correct observations.

Lesson

1. Give participants a copy of the page entitled "Signs and Symptoms to Report." Ask them to read through the signs and symptoms and tell you if there are any they don't understand. They may need explanations about why some of them are important to report.
2. Discuss the information in the rest of the lesson materials. You may want to bring copies of your organization's policies and procedures about reporting and recording observations.

Evaluation

Have the learners take the test, and grade the test together. Hand out certificates to those who answer at least 8 of the questions correctly.

Test Answers: 1. T, 2. T, 3. communication, 4. F, 5. a & b, 6. F, 7. a & b, 8. confidential, 9. a, 10. c, 11. signs, 12. change.

Observing, Reporting, & Recording

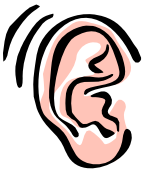
Learner's Guide

Observing

Observation is an important skill for everyone who works with people. Observation is the act of noticing or seeing something. It means being attentive to the people you see and to the things going on around you.

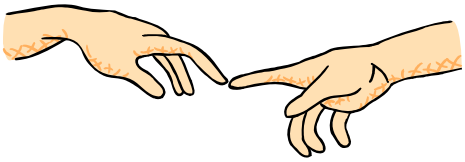
Train yourself to be a good observer. Learn to use all of your senses and be aware of your surroundings at all times, for your safety and the safety of others. What you see, feel, hear, touch, and smell can tell you important things about your clients and help you give the best possible care. Your coworkers and your clients depend on you to observe carefully, and to communicate and record your observations.

There are two categories of observations: **subjective** and **objective**.



Objective observations are the things you see, feel, hear, smell, or measure. They are also called **signs.** Temperature, pulse, respirations, and blood pressure are objective observations. When you notice redness or swelling somewhere on a client's skin, you are making an objective observation.
There are many things to observe, such as behavior, physical condition, reactions, activities, movement, eating, mental condition, changes in condition, and signs of illness.

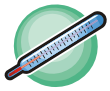
Subjective observations are things you are told, or things you have a feeling about. They are also called **symptoms.** Pain is a subjective observation. Only the client knows how much pain he or she is feeling, and no one else can judge his or her level of discomfort. We can **objectively** observe that the client is restless, or is making facial grimaces, or is moaning as if in pain, but the pain itself is a **subjective** experience. If a client tells you he or she is not feeling well, that is a subjective observation.

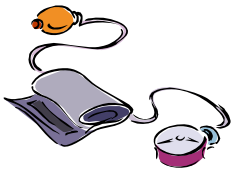


What Should You Observe?

These are some examples of things that can be observed or measured objectively, or that a client might report to you subjectively. Many things do not have to be measured on a regular basis unless it is part of the client's plan of care. Anytime anything seems unusual you should observe it more closely. Anytime the client expresses concern about something you should pay close attention. It is very important to observe and report ***changes*** in the client's normal condition or behavior.

Objective Information





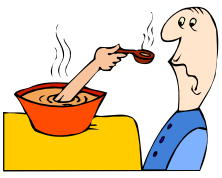
- Measurements:
  - Vital signs (if trained)
    - Temperature
    - Pulse
    - Respirations
    - Blood pressure
    - Weight
  - Urine output
  - Intake of liquids and solids
- Physical condition:
  - Swelling
  - Color of skin and nails (pale, flushed, yellow, gray, bluish)
  - Odors
  - Skin redness, irritation, bruises, breaks, tears, burns
  - Difficulty breathing
  - Coughing
  - Wound drainage
  - Firmness in the stomach area
  - Gas, incontinence
  - Skin condition and turgor (Is the skin dry? Does it return quickly to normal shape when pinched?)
- Activities, assisted or unassisted:
  - Bathing
  - Sleeping
  - Walking
  - Use of assistive devices
  - Movement
- Mental condition:
  - Awareness
  - Orientation (Do they know what time and day it is? Do they know where they are?)
  - Consciousness
  - Confusion
  - Mood
- Situations:
  - Falls
  - Rapid changes in condition
  - Accidents, burns, injuries

Subjective Information

- Client statements about:
  - Pain or discomfort
  - Appetite
  - Feelings
  - Other concerns

When Should You Observe?

Observe **ALL THE TIME.** When you are helping with a client's personal care, observe skin, hair, color, strength, flexibility, stamina, speech, behavior, color of urine, and other aspects of their physical and mental condition. When you are helping with a meal, watch what is consumed (food and drink, type and amount). When you are helping with ANY activity or aspect of care, even just talking to a client, stay alert and watch carefully for ***anything different or new*** and anything you should report or record.



How Should You Observe?

Use all your senses. Practice noticing details. Try these exercises:

- While shopping in a store, stop and concentrate on what you see, smell, hear, and feel. What is the air temperature? What smells can you identify? Count the number of different colors you see. Describe the people you see.
- When helping a client, count the number of different things you observe. What does the client smell like? What is the texture of the client's skin? Is the hair brittle or soft? What color are the nails? Are the client's eyes bright or dull?

Practice makes perfect—anyone can become an experienced observer.

Reporting

Report anything out of the ordinary to your supervisor or a medical person, even if you don't think it's important. Whenever you see, hear, smell, touch, or feel something that raises a question in your mind, ask about it. When in doubt, report!

⇨ Report ***immediately:***

- A fall
- Blood sugar over 200 or below 80
- A seizure
- Chest pain
- Distorted speech or paralysis
- A non-responsive client
- Any sudden serious changes in condition, such as difficulty breathing or sudden severe pain

To Whom Do You Report?

Your organization should have policies and procedures for you to follow when reporting observations. Be sure you know who you are supposed to notify in emergencies and who you should tell about observations or changes in condition.

How Do You Report?

Some organizations keep a Communication Book in which workers can record non-emergency observations for a nurse or supervisor to review. You may need to telephone a nurse or supervisor with your observations. Or, there might be a nurse in the building to hear your report.

What If No One Does Anything About Your Report?

First, ask your supervisor or nurse about it. Perhaps nothing can be done about the problem. Maybe someone is working on the problem, but it takes time. Or, maybe this isn't really a problem for this client. Sometimes unusual signs or symptoms can be normal for a particular individual. For example, someone with heart disease might be short of breath all the time. An explanation from your supervisor can put your mind at ease. **Do not assume something is normal, though, until you report it and find out.**

If you feel no one is paying attention to a problem, and the problem continues, keep reporting it! Record who you tell, and what you tell them.

Recording

The Record

The record is used in every aspect of planning and delivering care. It is one way members of the care team communicate. It documents care. This helps with continuity of care and protects the financial and legal interests of the client, the organization, and the care providers. The record must be complete.

Every organization has its own policies and procedures about what to put in the record and how to do it.

Generally, each time a worker does or observes something involving a client, the worker should record what was done or observed. Record symptoms the client reports. Record when you notify your supervisor of a problem. Record condition changes. Record the client's response to care.

If your organization records information "by exception," you will only write down things that are different from the client's usual routine or condition.

How Should You Record?

Documentation is one of the most important duties workers perform. Effective documentation is timely, systematic, accurate, descriptive, and clearly written. It must comply with standards established by accrediting and licensing organizations, state and federal agencies, insurance companies, and the employer.

How care is recorded varies among facilities and agencies. These are the basics:

1. The client's record and information is **confidential.** Do not discuss any information about clients away from work or with anyone other than the people taking care of the client. This protects the client's right to privacy.

2. The client's record is essential for **well-coordinated care.**
   a. Be factual—write what you did, what happened, what you observed, what the client said. Put quotes around words the client said so the record is clear about what happened and what was said by whom. Don't make judgments, just state the facts.
   b. Use only the abbreviations allowed and understood in your organization.
   c. Be exact about the time things occur.
   d. Be brief. Stick to the main point. Be specific.

3. The client's record is a **legal document.**
   a. Write legibly in ink.
   b. Draw lines through mistakes and initial them. Do NOT white-out or erase.
   c. Draw lines through unused spaces so no one can write in them later.

4. The client's record is **about the client.** It is not the place to write about problems with coworkers, supervisors, or short staffing.

Learning Activity: Observation Skills

Cover the questions below. Look carefully at the picture above for one minute or less. When you are finished, cover the picture with a piece of paper.

Now, what do you remember?

1. Briefly describe what you saw in the picture.

_____

2. Name one shape that was on the blackboard.

_____

3. Was anyone in the picture wearing glasses? If so, who?

_____

4. What did the students have in front of them on the desk?

_____

5. How many females were in the picture? _____ How many males? _____

Signs and Symptoms to Report

It is important to report these signs and symptoms, especially if they are new or represent a change in the client's usual condition.

Vital Signs
Temperature over 100ºF oral, 99° axillary or 101° rectal
Pulse over 100 or under 60 or irregular
Respirations under 10 or over 24, or irregular or shallow
Blood pressure less than 90/60 or more than 140/90
Weight gain or loss of 5 pounds or more
Blood sugar over 200 or below 80

Mental or Emotional
Tearfulness, depression
Anxiety or tension
Agitation or sleepiness
Disorientation
Distorted speech
Dizziness or fainting
Problem with coordination or gait
Seizure
Weakness, paralysis
Numbness or tingling
Tremors (shaking)
Headache

Skin
Hot, sweating
Cold and clammy
Nail beds bluish color
Color changes
Swelling
Bruises
Bleeding
Rash, sores, or lumps
Itching
Excessive dryness
Surgical incisions (drainage, odor, swelling, redness)

Muscles and Bones
Joint pain
Back pain
Limitation of motion
Swelling of extremities
Loss of strength or function

Eyes
Problem with vision
Redness or discharge

Ears
Inability to hear
Earache
Drainage

Nose
Nasal stuffiness
Nosebleed

Mouth and Throat
Sore throat or sore tongue
Hoarseness
Bleeding gums

Neck
Pain or stiffness
Swollen glands

Chest and Breathing
Pain
Palpitations
Shortness of breath
Cough
Sputum (amount, color)
Wheezing

Breast
Pain
Nipple discharge

Stomach
No appetite
Excessive thirst
Nausea
Vomiting
Indigestion, pain, discomfort
Diarrhea (color, amount)
Constipation
Hemorrhoids
Rectal bleeding

Urinary
Frequency or urgency
Dribbling of urine
Blood in the urine
Burning or pain
Incontinence (Unable to control urine)
Foul odor to urine

Female Reproductive
Vaginal discharge, bleeding, itching, soreness, discomfort, or pain

Male Reproductive
Penile discharge or lesions

Observing, Reporting, & Recording: Test

Name _____ Date _____ Score _____
(Must answer at least 8 questions correctly)

Directions: Circle or write the correct answer or answers.

1. Both subjective and objective information should be observed. True or False

2. A good rule of thumb is to report anything out of the ordinary. True or False

3. The record serves as a means of _____ between members of the care team.

4. Subjective symptoms are those the worker observes. True or False

5. Examples of subjective symptoms are:

   a. Pain in the arm
   b. Headache
   c. Rash on the leg
   d. A red area on the skin

6. Objective symptoms are those the client tells the worker. True or False

7. Examples of objective symptoms are:

   a. Elevated blood pressure
   b. Blood in the urine
   c. Anxiety
   d. Dizziness

8. To protect the client's right to privacy, all information in the client's record and all information you know about the client must be kept _____.

9. When recording information in the client's record:

   a. Be factual, accurate, descriptive, and brief.
   b. Write in pencil so you can erase your mistakes.
   c. Write down things your coworkers did wrong.

10. When you observe that a normally calm client is suddenly acting agitated or confused for no apparent reason, you should:

    a. Ignore the client until he/she calms down.
    b. Call the family to come sit with the client.
    c. Notify your supervisor or a medical person.

11. Objective observations are also called _____.

12. A new sign or symptom, or a _____ in condition, should always be reported.

Certificate of Completion

Awarded to: _____
(Name of Participant)

For Completing the One-Hour Course Entitled

Observing, Reporting, & Recording

Date of Course: _____

Organization: _____

Presented by: _____
(Signature of presenter, or write "self-study")