

# Documenting Care

---

2 credit hour course

One of the most important things that you will do as a professional caregiver is keeping proper documentation when taking care of a patient. This medical record is a **document**, a legal record. The process of recording the patient's care, response to treatment, and progress in the patient's chart is called *charting or documentation*.

A patient's medical record, or chart, is a legal document that can be used in a court of law as evidence. It is important that you make sure that everything that you write be correct and legible. Everything that you write down must be in clear, simple, and accurate language. Entries must be printed or written carefully so that there can be no misunderstanding of the meaning. If you follow the established rules of documentation, there will be no issues.

Each chart relates only to one patient, so it is unnecessary to use the term patient or use the patient's name. Use phrases rather than full sentences, and do not make erasures or leave empty spaces on the record. All entries are made in black ink because the chart is a permanent record; no erasable ink or correction fluid is allowed.

If you use medical terms in your charting, make sure that you are using the correct words and that spelling is correct. Use a medical dictionary if you are not sure. Abbreviations are allowed, but they must be approved for use by your company or facility. Do not make up your own abbreviations. You must chart only for yourself and only when the procedure or assignment has been completed.

## **MAKING OBSERVATIONS**

An **observation** is information that is being obtained by using one's senses: seeing, hearing, smelling, or feeling. This information can help the care team determine:

- A change in the patient's physical condition.
- A new condition that is developing.
- A change in the patient's mental condition.
- A change in the patient's emotional condition.
- The effectiveness of a medication or treatment.

There are two types of observations: subjective and objective. An **objective observation** is one that is based on facts that can be measured in some way. An example of this would be blood in the urine.

Blood pressure, temperature, pulse, and respiration are all measurable. A **subjective observation** is a statement or complaint made by the patient. An example of this would be a patient saying "I have a headache".

What kind of observations can you make by using your senses? Here are a few examples:

- **Eyes** (to see an observation) Examples: blood in the urine, bruises on the skin, patient is crying, change in the way the patient walks.
- **Ears** (to hear observations) Examples: wheezing when patient breathes, pulse or blood pressure, comments from the patient.
- **Nose** (to smell observations) Examples: body odor, discharge from a wound or body cavity, stool or urine when the patient is incontinent.
- **Hands/Fingers** (to feel observations) Examples: lump under the patient's skin, radial pulse, warmth or coolness of the patient's skin.

It is important to remember that observations must be:

- Accurate and timely
- Reported to the nurse in a timely manner
- Documented in the patient's record, either by you or the nurse

In addition to observations of the body, you should also note facts related to pain, behavior, and function.

- Pain: note the location, type of pain (sharp, dull, aching), constant or intermittent or related to specific activities, note time that pain started.
- Behavior: actions, conduct
- Function: ability to move about and complete tasks such as bathing

When reporting behavior, avoid using labels based on your judgment of the patient. Report only what you see and hear. You may make additional observations related to the patient's medical diagnosis. In some situations, you may be expected to report normal observations. This will tell the nurse and doctor whether the patient's condition is improving.

Listed below is a list of general signs and symptoms of illness that should be reported to the nurse:

- Chest pain, nausea or vomiting, lethargy
- Shortness of breath, diarrhea, unusual drainage from a wound or body cavity
- Difficulty breathing, cough, changes in vital signs
- Weakness or dizziness, Cyanosis or change in color, profuse sweating
- Headache, change in mental status
- Pain, excessive thirst

You will learn when you should report your observations about patients as you gain more experience in the profession. In general, high-priority items for reporting include abnormal vital signs, chest pain, difficulty breathing, change in color, change in mental status, bleeding, and pain. If you have any doubts about the urgency of reporting to the nurse, report your observation

immediately. If the condition of the patient changes after you have reported to the nurse, inform them again.

Reporting and recording your observations of patients are key nursing assistant responsibilities. Pay attention to details. Practice good communication skills. As you gain more experience you will learn which observations must be reported immediately and which can wait until the end of your shift. An alert, observant nursing assistant is invaluable in protecting patients' safety and well-being.

# Test

---

The following is a set of three scenarios. On a separate piece of paper, you are to type up a report detailing all pertinent information regarding the incident. Be clear and concise. You should begin your report with the client's name, age, and current medical status. Be sure to then include the address. Next, describe the incident, exactly what you observed, approximate time, and what, if any, follow-up action was taken. When you have completed your report remember to sign your name and specify your title.

Client name: Jonathan Smith, age 79, recovering from stroke

Address: 12345 Apple Lane, Orchard, WA 98888

## Scenario 1

Mr. Smith was feeling well enough to travel with his son Daniel to the mall. They return a few hours later. Jonathan seems rather distant, not speaking to you. When you are changing his clothes later that evening, you notice bruising on his arms and legs. When asked about them, Mr. Smith states he fell when his son Daniel became angry and pushed him to the ground.

## Scenario 2

Jonathan Smith was alone in his bedroom. You are in the kitchen cleaning up after dinner. You hear a crash and find Mr. Smith lying on the bedroom floor. He states that his head is hurting. You don't see any redness or open wounds, no bleeding. He wants to get up off the floor.

## Scenario 3

Jonathan is eating breakfast in the morning and spills his coffee in his lap. He complains of burning on his upper legs and stomach.

**How to Apply for Course Credit:**

Please fill out the information below and mail it in with your test answers and payment of **\$10** to:

Health People, Inc.  
12501 Bel-Red Road, Suite 214  
Bellevue, WA 98005

Upon verifying completion, we will mail you the certificate for **2 CEU** credits to the address you provide.

Name \_\_\_\_\_

Institution/Facility \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Date of Course Completion \_\_\_\_\_

(this date will appear on your certificate)

Signature \_\_\_\_\_

**Payment Type:**

Check made payable to Health People, Inc.

Credit Card Payment:  Visa  MasterCard

-----  
Credit Card Number \_\_\_\_\_ Month Year Expire Date \_\_\_\_\_

X \_\_\_\_\_

Signature (as it appears on the credit card)