

# Observing, Recording, and Reporting

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## THE FACTS ABOUT OBSERVING, RECORDING, AND REPORTING:

You spend more time in the home with patients than any other staff member. Therefore, you may be the first to recognize changes in their conditions. By observing and reporting these changes you can increase their chances of recovery. You should report changes in patients even if the nurse will be making a visit later that day. In addition to helping your patients, your observations and reporting also help the nurses and therapists do their jobs better. Good observing, recording, and reporting also help your agency. During a survey of your agency, the surveyor will review your notes to see whether you did the important parts of your job. Those include recording the duties you were supposed to perform, as well as whether or not you observed and reported anything out of the ordinary.

## METHODS OF OBSERVING PATIENTS:

Many people think observation means simply looking at something or someone. However, there are many different ways you can and should observe patients. They include the following:

- » Looking — for example: bruises or rashes; problems with transferring or ambulating
- » Touch or feeling — for example: cold clammy skin
- » Listening to the patient's body — for example: congested coughing
- » Listening to what the patient reports — for example: complaints of pain, nausea, etc.
- » Smelling — for example: foul-smelling urine

On every visit you make to the patient, you will be constantly observing. Some of the more important observations you will need to make include:

- **Skin** — Because you are giving or assisting with a bath, you have more opportunity to observe the skin than anyone else. You must especially pay attention to things that are not normal for this patient. Some of the things you should always look for include:
  - » Color — Is the patient very pale? Are there areas of discoloration, especially in the legs and feet? Are there any reddened areas, particularly on bony prominences? Are there any bruises? Are the lips bluish?
  - » Temperature — Does it feel especially hot or cold anywhere? Is there warmth or coolness only in certain areas?
  - » Swelling — Is there swelling or puffiness? Look around the eyes, the joints, and the legs and feet.
  - » Open areas — Is there any new skin breakdown? Are there any cuts, cracks, scrapes, or skin tears?
  - » Pain — Does the patient show signs of pain when you touch certain areas?
  - » Numbness — Are there some areas where the patient says he or she feels numb?
  - » Smell — Is there an odor coming from the skin? Especially from dressings?
- **Eyes, Ears, Nose**
  - » Eyes — Is there any crusting or discharge? Is there any redness around or in the eyes?
  - » Ears — Is there any drainage or discharge?

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» Nose — Is there drainage or discharge? Any bleeding?

- **Urinary System** — Closely observe the urine whenever the patient urinates. If the patient is incontinent and wears a diaper, look at the diaper. If the patient has a catheter, carefully observe the clarity, color, odor, amount, as well as presence of sediment or mucus in the bag.
- **Digestive System** — If the patient has a bowel movement, note if it appears normal for him or her. Observe for constipation or diarrhea. If the patient is incontinent, when does it happen? Observe for changes in appetite.
- **Neuromuscular System** — Watch the patient while ambulating, transferring, and moving about in bed. Look for any twitching, tremors, or limited or difficult movement.

In addition to the observations above, there are also things you may know about only by listening to the patient. These things cannot be seen, heard, touched, or smelled. You must accept what the patient tells you about them. They include such things as pain, nausea, light-headedness or dizziness, ringing in the ears, numbness, tingling, or inability to sleep.

## RECORDING AND REPORTING — SUBJECTIVE AND OBJECTIVE:

There are basically two types of recording and reporting — subjective and objective. Objective recording and reporting is the only type you should use.

Objective is what you actually observed, or exactly what the patient/family told you. For example: “Mr. Jones has a runny nose and a cough. He says his daughter has had a cold” is objective.

Subjective is an opinion, or what you think. For example: “Mr. Jones caught a cold from his daughter” is subjective.

## WHAT MUST BE REPORTED:

Reporting means calling the nurse, therapist, or supervisor. No doubt your agency has policies on what needs to be reported and whom you should call to make a report. However, you should always report changes in the patient that are new or different. Some of these include:

- » Items to report specifically listed on your assignment sheet. (For example: “report BP greater than 150/90.”)
- » Patient refusal to allow you to provide care listed on the assignment sheet
- » Patient falls either while you are there or as reported by patient/caregiver
- » Pain that the patient says is not controlled by medication
- » Confusion when the patient is not usually confused
- » Severe chest pain, and
- » Emergencies occurring during your visit. (In an emergency situation, follow your agency’s procedure for emergency response.)

## WHAT MUST BE RECORDED:

Recording means writing the information on your visit report. Your agency likely has some recording guidelines for you

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to follow. It is important to record on the visit note as soon as possible. You must always record the assigned duties you completed. A rule of thumb is that you also need to record anything that you reported. Keep in mind that the recording must be objective. In addition to your assigned duties, you should record in your visit note:

1. What you observed that needed to be reported
2. The date and time you made the report, and
3. The name of the person to whom you made the report

## CASE STUDY: OBSERVING, RECORDING, AND REPORTING

Mrs. Martinez is an 80-year old patient with an indwelling catheter. LaKeisha visits two times a week to assist with a shower and personal care. The nurse visits once a month to change the catheter and every two weeks to supervise the aide services.

One morning, LaKeisha noticed that Mrs. Martinez did not seem quite as alert as usual. Her skin was its usual color and her breathing was the same as always. The first thing LaKeisha did was to look at the urine in the drainage bag which was its usual clear, light yellow. She started to assist Mrs. Martinez to sit on the side of the bed so she could use her walker to go to the bathroom for her shower. Mrs. Martinez seemed to slump towards the right, and did not use her right arm to steady herself. LaKeisha steadied her and then suggested she should lie back down in bed. Once Mrs. Martinez was lying down, LaKeisha asked her to raise her right arm. She was not able to do a full range of motion, and the arm was weaker than usual. She also had some weakness in her right leg. LaKeisha asked Mrs. Martinez whether she had noticed the weakness and Mrs. Martinez said it only started that morning. LaKeisha told Mrs. Martinez that she thought she should report this to the nurse and encouraged her to just lie in bed and rest. Mrs. Martinez asked LaKeisha not to call the nurse. She said that she had had these spells before and they always went away. LaKeisha talked with Mrs. Martinez and told her that there was a definite change in her, and that it was important for the nurse to know about it. She called the nurse to report the weakness in Mrs. Martinez's right arm and leg, and stated that she did not think she could safely transfer into the shower. The nurse advised LaKeisha to do a bed bath rather than a shower, not to assist with any exercises, and to keep Mrs. Martinez in bed. The nurse talked with Mrs. Martinez and told her that she would be calling the doctor and would likely make a visit.

LaKeisha completed the cares for Mrs. Martinez, and did her documentation. She wrote in the visit report that the right arm and leg appeared weak and that Mrs. Martinez slumped towards the right when she sat on the side of the bed. She also wrote that Mrs. Martinez said she noticed the weakness that morning and reported having the weakness before. LaKeisha wrote that she informed the nurse (giving the nurse's name), listing the date and time of the phone call. She also wrote that the nurse instructed her to give a bed bath instead of a shower, not to do any exercises, and not to get Mrs. Martinez out of bed.

The next day, the nurse called LaKeisha to tell her that Mrs. Martinez was in the hospital. The weakness in her arm and leg was an early sign of a possible stroke, but because of LaKeisha's observation and reporting, they had been able to give Mrs. Martinez medications that prevented her from having any long-term effects.

## SOMETHING TO THINK ABOUT

Were LaKeisha's reporting and recording objective? Why or why not? Are these the things you would have done? List as many reasons as you can why it was so important for LaKeisha to report what she observed.



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DIRECTIONS: READ EACH QUESTION CAREFULLY. THEN, DETERMINE THE BEST ANSWER. CHECK THE CORRESPONDING BOX ON YOUR ANSWER SHEET. DO NOT WRITE ON THIS POST-TEST.

1. Which of the following is not objective recording?
  - a. I don't think he feels good today.
  - b. There is a new reddened area the size of a dime on his left hip.
  - c. He says he is light-headed today.
  - d. His urine is much darker than usual.
  
2. Which of the following is true about observing and reporting?
  - a. You should only report what you see.
  - b. It is not necessary to report that the patient says she is dizzy if she doesn't act like she is dizzy.
  - c. You should not report something if the patient asks you not to.
  - d. You should report changes you observe in the patient.
  
3. Which of the following should you always report?
  - a. The duties listed on your assignment sheet were all done.
  - b. The patient said she fell last night.
  - c. The patient's vital signs if taken.
  - d. All of the above
  
4. Which of the following should you always record on your visit note?
  - a. The duties listed on your assignment sheet were all done.
  - b. The patient said she fell last night.
  - c. The patient's vital signs if taken.
  - d. All of the above
  
5. It is not important to record and report a change in the patient if the nurse is making a visit later today.
  - a. True
  - b. False
  
6. Which of the following is true about objective and subjective recording?
  - a. Subjective recording is recording exactly what you saw.
  - b. Objective recording is recording what you think about the patient.
  - c. Subjective recording is the type of recording you should use.
  - d. Objective recording can describe something you observed by touching.

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POST-TEST, PAGE 2

7. Why is it important for a home health aide to know what to report?
- Reporting changes in patients may increase their chances of recovery.
  - Changes you report will help the nurses do their jobs better.
  - Reporting is an important part of a home health aide's job.
  - All of the above
8. Which is the best example of objective recording?
- "I don't think Mrs. Bell takes care of herself."
  - "Mrs. Bell says she feels bad but she looks all right to me."
  - "Mrs. Bell says she was sick to her stomach and threw up three times last night."
  - "Mrs. Bell whined all during the visit."
9. It is not necessary to record something in your visit report if you reported it to the nurse.
- True
  - False
10. Which of the following is true about recording something you reported?
- You should always include what you observed, when you made the report, and the name of the person you reported to.
  - It is better to wait a few days to record so you can think about it for awhile.
  - All you need to record is, "Called the office."
  - You should always include your opinion about the meaning of what you reported.

-END-

# MONTHLY INSERVICE ANSWER SHEET

In-service Month \_\_\_\_\_ Year \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

1. a. \_\_\_ b. \_\_\_ c. \_\_\_ d. \_\_\_

2. a. \_\_\_ b. \_\_\_ c. \_\_\_ d. \_\_\_

3. a. \_\_\_ b. \_\_\_ c. \_\_\_ d. \_\_\_

4. a. \_\_\_ b. \_\_\_ c. \_\_\_ d. \_\_\_

5. a. \_\_\_ b. \_\_\_ c. \_\_\_ d. \_\_\_

6. a. \_\_\_ b. \_\_\_ c. \_\_\_ d. \_\_\_

7. a. \_\_\_ b. \_\_\_ c. \_\_\_ d. \_\_\_

8. a. \_\_\_ b. \_\_\_ c. \_\_\_ d. \_\_\_

9. a. \_\_\_ b. \_\_\_ c. \_\_\_ d. \_\_\_

10. a. \_\_\_ b. \_\_\_ c. \_\_\_ d. \_\_\_

