

Observing, Reporting, Charting

See it and Say it



The Nursing Process

- 1. Assessment- (Observations)
- Collect data (info) strengths/problems
- Listen and observe carefully
- Measure carefully
- Report findings/changes
- Document
- 2. Planning- developing care plan
- Participate in care conference
- Identify solutions to problems
- Develop approaches/interventions
- Establish goals- must be measurable- for example (within 10 days the resident will have no S/S of UTI)



The Nursing Process (con't)

- 3. Implementation- carry out approach
- Who is going to do it.
- When the approach is done
- How will it be done.
- 4. Evaluation- have goals been met?
- If not, why?
- What still needs to be done.
- Review the new plans of care
- Aids need to report if approaches can't be carried out or if patient is having problems with the approach.



C.N.A.'s as medical scouts

- As the primary caregiver, your observations can be the difference between a resident who receives early and effective treatment, and a resident who becomes gravely ill.
- A recent study by Kenneth Boockvar MD, Assistant Professor in the Department of Geriatrics at Mount Sinai School of Medicine found:
- That C.N.A.'s almost always saw that a resident was becoming ill earlier than anything noted in chart.
- Illnesses that were detected early were:
UTI's, pneumonia, CHF, gastroenteritis, arrhythmias, and dehydration.

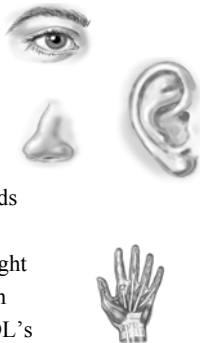
The 5 early warning signs of illness

- 1. Weakness- sudden onset
TIA, pneumonia, dehydration, CHF, infection, liver failure.
- 2. A change in greeting
severe hearing loss, depression, confusion.
- 3. Nervousness or agitation
being emotionally off can signal physical illness.
- 4. Loss of appetite
- 5. A resident complains



Observations by Body Systems use sight, touch, hearing and smell to gather info.

- Integumentary System**
- color - flushed, pale, ashen, icteric, cyanotic, don't forget nails.
- temperature - warm, hot, cool,
- moisture - dry, moist, perspiring
- abnormalities- rashes, bruises, wounds
- Musculoskeletal System**
- posture- stooped, fetal position, straight
- mobility- in bed, balance, ambulation
- range of motion- performance of ADL's



More about you being the eyes and ears

➤ Circulatory System

- pulse- strength, regularity, rate
- blood pressure
- skin- color
- extremities- edema

➤ Respiratory System

- respirations- rate, regularity, depth,
- dyspnea, SOB (exertion, at rest)
- stertorous.
- cough- frequency, dry, productive,
- sputum- color, consistency



More about Observations

➤ Nervous System

- mental status- orientation
- ability to communicate

➤ Senses

- eyes- pupils equal, reddened, drainage.
- Ears- drainage, hearing
- nose- drainage, bleeding

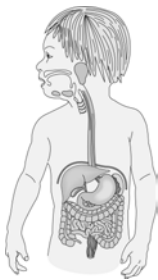
➤ Urinary System

- frequency, amt., color, dysuria
- clarity, blood or sediment, incon.

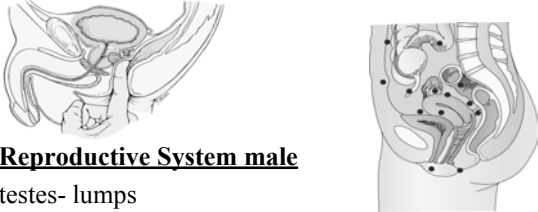


➤ Digestive System

- appetite- amt. of solids/liquids consumed, belching, burping, intolerance to foods.
- eating- difficulty chewing or swallowing.
- nausea/vomiting
- bowel elimination- frequency, amt. consistency, color, diarrhea, constipation, incontinence, flatus.




☛ **Reproductive System female**
 breasts- any drainage from nipples, discoloration, lumps.
 ☛ vaginal- any discharge, amt. odor, character



☛ **Reproductive System male**
 ☛ testes- lumps
 ☛ penis- amount and character of drainage


Don't Forget the ABC's of Observation

☛ **A**ppearance- has been covered by observations of body systems.
 ☛ **B**ehavior- actions, conduct, pain
 ☛ **C**ommunication- has been covered



Two types of Observations

☛ **Objective**- signs that you can see, hear, feel, smell
 ☛ factual, measurable
 ☛ Can you think of examples?
 ☛ **Subjective**- what the resident tells you.
 ☛ Can you think of examples?



Now that you saw it, Say it!

Reporting Your Observations.

- Be objective, don't interpret observations.
- write it down
- report only the facts
- do not make assumptions
- consider the patient's culture
- never compare residents
- oral reports are given by the nurse or aide going off duty to the oncoming shift, the aide to the nurse during the shift, and at the end. Did you notice anything unusual?
- Don't be shy- "I'm worried that..."



Documentation/Charting in medical record/legal document

- Must be legible, print, no ditto marks.
- Use black or blue ink
- do not use the term patient
- use short, concise phrases
- always chart after the event
- always indicate the time
- leave no blank lines
- proper signature
- never erase, single line through, initials
- use appropriate medical terms/abbreviations
- use international time, or follow policy.