Module 15: Observation and Charting
Minimum Number of Theory Hours: 4
Recommended Clinical Hours: 4

Statement of Purpose:
The purpose of this unit is to prepare students to know how, when, and why to use objective and subjective observation skills. They will report and record observations on appropriate documents using medical terms and abbreviations.

Terminology:

1. Abbreviation
2. Activities of Daily Living (ADL)
3. Assessment
4. Assessment Reference Day (ARD)
5. Incident report
6. Kardex
7. Minimum Data Set (MDS)
8. Objective
9. Observation
10. Paraprofessional Healthcare Institute (PHI) http://phinational.org/about/
11. Prefix
12. Range of Motion (ROM)
13. Resident Assessment Instrument (RAI)
14. Resident Assessment Protocol (RAP)
15. Resident care plan
16. Root word
17. Subjective
18. Suffix

Performance Standards (Objectives):
Upon completion of the four (4) hours of class plus homework assignments and four (4) hours of clinical experience, the learner will be able to:

1. Define key terminology.
2. Identify word elements used in medical terms.
3. Identify medical terminology and abbreviations commonly used in medical facilities.
4. Define observation and list the senses used to observe a resident.
5. Describe objective and subjective observations.
6. List types of charting documents and the use for each.
7. Explain how to accurately complete ADL assessment for MDS.
8. Discuss procedures to use when recording on a resident's chart.

References:

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Content Outline	Recommended Teaching Strategies and Assignments	Clinical Demonstration/ Method of Evaluation
Objective 1 **Define key terminology** A. Review the terms listed in the terminology section. B. Spell the listed terms accurately. C. Pronounce the terms correctly. D. Use the terms in their proper context.	A. Lecture/Discussion B. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman, and concentration. C. Encourage use of internet, medical dictionary, and textbooks D. Create flashcards for learning purposes. E. Handout 15.1a- Observation and Charting Crossword F. Handout 15.1b- Observation and Charting Crossword- KEY	A. Have students select five words from the list of key terminology and write a sentence for each defining the term. B. Administer vocabulary pre-test and post-test. C. Uses appropriate terminology when charting and reporting to licensed personnel.
Objective 2 **Identify word elements used in medical terms.** A. Medical words are composed of several small words or word elements. B. Word elements 1. Root. 2. Prefix. 3. Suffix. 4. Combining vowel.	A. Lecture/Discussion B. Handout 15.2- Prefixes and Suffixes	A. Written test B. Class participation
Objective 3		

Identify medical terminology and abbreviations generally used in medical facilities. A. Identify medical terminology and abbreviations from list determined by instructor. B. Abbreviations are/may be 1. A shortened form of words or phrases. 2. Commonly used in health care settings. 3. Designations for medical specialty areas: ER, OR, OB, etc. 4. Shortened forms of a word or the first letters of a word: amb, BRP, lab, etc. 5. A shortened form of a Latin or Greek word: ad lib, prn, po, etc. C. Refer to facility policy on approved abbreviations.	A. Lecture B. Discussion	A. Written test B. Class participation C. Uses correct terms and abbreviations in charting.
Objective 4 **Define observation and list the senses used to observe a resident.** A. Observation – use of senses to collect information about a resident. 1. Senses used for evaluation a. Sight b. Touch c. Hearing d. Smell 2. Observations should be made with regard to a resident's a. Skin color and temperature. b. Mood and mental status. c. Behavior, movement. d. Unusual odors. e. Respiration. f. Ability to respond. g. Appetite. h. Performance of ADL. i. Elimination. j. Pain or discomfort. 3. Learn to observe the resident throughout daily contacts noting any	A. Lecture/Discussion B. Role-play a scene and have students write down their observations when scene is over.	A. Written test B. Class participation

changes or needs. 4. Report all changes or needs to licensed nurse. B. ABCs of observation 1. Appearance. 2. Behavior. 3. Communication.		
Objective 5 **Describe objective and subjective observations.** A. Objective 1. Signs that you can see, hear, feel and smell. 2. Factual, measurable and/or observable signs. B. Subjective 1. What the resident tells you. 2. Not directly seen (observed) by the nurse assistant. 3. Symptoms reported by resident.	A. Lecture/Discussion B. Develop lists of observable signs and statements from client and items that would not have been observed directly. Ask students to label as Objective or Subjective.	A. Written test B. Class participation
Objective 6 **List types of charting documents and the uses for each.** A. Resident record and resident's chart 1. Communicates and records health history, status, and treatment. 2. A legal record. B. Kardex 1. Summarizes physician's orders. 2. Identifies critical data such as allergies, code status, diet, activity, etc. 3. Gives medication and treatment information. C. Nursing care plan 1. Lists resident's need and provides specific nursing activities that address the resident's needs. 2. A guide for the Nurse Assistant for delivering care. D. Graphic sheet - used in some facilities to document.	A. Lecture/Discussion B. Examples of Mock Charts C. Example of Kardex	A. Written test B. Class participation

1. Vital signs. 2. Intake and output. 3. Weight. E. ADL sheet 1. Used to document care at each shift for activities of daily living. 2. The record on which most facilities have the care work chart.		
Objective 7 **Explain how to accurately complete ADL assessment for MDS.** A. Minimum Data Set (MDS) 1. Mandated assessment tool by Federal regulation (483.20 (b)) and (F272) to give facility structured, standardized approach to care. 2. Basis for payment/or reimbursement to the facility. B. Resident Assessment Instrument (RAI) 1. Each facility must use its state-specified RAI to assess newly admitted residents, conduct an annual reassessment and assess those residents who experience a significant change in status. 2. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the Minimum Data Set (MDS) or Resident Assessment Protocol (RAPs). 3. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident. C. MDS Section G refers to physical functioning and structural problems. 1. Bathing. 2. Functional limitation in Range of Motion. 3. Modes of Transfer. D. Assessment Reference Day (ARD) 1. ARD – set date for the last day of assessment period. 2. Assessments are made during the seven days preceding the ARD (the look back period). 3. Example: ARD is Jan. 8. Therefore, the look back period of observation will start from Jan. 2 until Jan. 8.	A. Lecture/Discussion B. Refer to MDS form Section G Appendix 7.5. ONLINE FORM C. Refer to Appendix H-MDS Version 3.0 All Forms Access form at http://www.cms.hhs.gov/nursinghomequalityinits/	A. Written test B. Class participation C. Document resident ADL functioning using the ADL flow sheet.

E. Two categories of ADL section: 1. Resident ADL Self-performance - what the resident actually did for himself or herself and/or how much verbal or physical help was required by staff members during all shifts. 2. Resident ADL support provided or needed. F. The reporting of the Nurse Assistant on changes in resident assessment may "trigger" (identify) a problem that needs evaluation and require care planning by the licensed nurse. G. Coding for ADL Self-performance: 1. 0: Independent – no help or staff oversight –OR – staff help oversight provided. Only one or two times during the last seven days. 2. 1: Supervision – oversight, encouragement, or cueing provided three or more times during the last seven days – OR – supervision (three or more times) plus physical assistance provided, but only one or two times during the last seven days. 3. 2: Limited Assistance – resident is highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance on three or more occasions – OR – limited assistance three or more times), plus more weight-bearing support provided, but for only one or two times during the last seven days. 4. 3: Extensive Assistance – while the resident performed part of the activity over last seven days, help of following type(s) was provided three or more times: a. Weight bearing support three or more times. b. Full staff performance of activity (three or more times) during part (but not all) of last seven days. 5. 4: Total Dependence – full staff performance of the activity during entire seven days period. There is complete non-participation by the resident in all aspects of the ADL definition task. 6. 8: Activity did not occur – over the last seven days, the ADL		

activity was not performed by the resident or staff. In other words, the particular activity did not occur at all. H. ADL support provided: 1. 0 – No set up or physical help from staff. 2. 1 – Set up help only. 3. 2 – One person physical assist. 4. 3 – Two + persons physical assist. 5. 8 – ADL activity itself did not occur during entire seven days.		
Objective 8 **Discuss procedures used when recording on a resident's chart.** A. Charting procedures 1. Make sure you have the correct chart or ADL sheet. 2. Write legibly and neatly. a. Write notes on paper first. b. Check for accuracy and spelling. 3. Place events in proper sequence. 4. Chart according to facility/policy standards. 5. Be concise and use appropriate terms and abbreviations. 6. Always use ballpoint pen. a. Black ink. b. No felt tip, fountain pens, pencils or gel pens. c. Use color only if approved in facility policy. 7. Errors – cross out with one line a. DO NOT ERASE OR USE WHITEOUT. b. Write "error" above the line. c. Initial the entry. 8. Include resident's complete information on each page. a. Some facilities have imprint stampers. b. If not, write in resident's name and any other information as the facility mandates. 9. Never skip lines. 10. Signature example; J. Jones, Nurse Assistant or R. Smith, NA.	A. Lecture/Discussion B. Handout 15.8- Charting Guides. C. Use chart forms from facilities for charting exercises.	A. Written test B. Class participation C. Documents observations promptly and correctly according to facility policy.

11. Always date and time entries – or make sure you are charting under correct date and time. 12. Chart only procedures YOU HAVE PERFORMED – and only after you have performed the procedure. 13. Never chart for someone else. 14. Chart only those observations which you know to be true (objective data). a. Do not chart opinions. b. Subjective data must be in quotation marks and exactly as the resident states. B. Computers and charting 1. Some facilities may have a computerized charting system. 2. Basic principles of charting apply – confidentiality and privacy are important issues. 3. Systems are password protected. a. Each user receives a personal password. b. Never share and/or use others' passwords. c. Sharing/using another's password may be grounds for termination. C. Legal issues of charting 1. Resident's record is a legal document; it can be used in a court of law. 2. Information in the chart must be kept confidential. 3. Information in the chart should be accurate, objective and truthful. 4. The Nurse Assistant has access only to the charts of the residents for whom they are caring.		

Sample Test: Module 15- Observation and Charting

1. Which of the following most completely defines observation?
   A. Watching the activities of the resident.
   B. Listening to the resident and to staff reports.
   C. Reading the charts and records.
   D. Gathering resident information by using the four main senses.

2. An error made while writing in the resident's chart is corrected by:
   A. Crossing out the mistake until it can no longer be read.
   B. Tearing out the sheet of paper in the chart and write on a new one.
   C. Drawing a line through the wrong entry and write an explanation of why it was an error.
   D. Drawing a single line through the entry, writing the word "error" above the line, and initial the entry.

3. Which of the following statements is an example of objective data or information?
   A. "Mrs. O'Hara said she felt sick to her stomach."
   B. "Mr. Jones says he has pain in the lower part of his back."
   C. "Mrs. O'Hara complained of feeling chilled, so I closed the window."
   D. "Mr. Jones vomited 250cc of fluid after lunch."

4. Using the following statement, identify the sentence that uses the correct abbreviations: Resident up in wheelchair all afternoon. Range of motion done three times a day. Physical Therapy to ambulate resident after meals every day. Resident may be out of bed as desired.
   A. Res. in w/c all P.M. ROM TID. P.T. to amb. res. pc qd. Res. OOB ad lib.
   B. R. up in W/C all P.M. ROM three qd. Phys.Ther. to amb. R. pc qd. R. out of bed ad lib.
   C. Res. up in wc. qd Range of mot tid. Pt. to amb res qd Resident may be oobed prn.
   D. Res. up in wc. No c/o pain. To x-ray for UGI series.

5. The words “ambulatory,” “bathroom privileges” and “before meals” are correctly abbreviated in only one of the sentences below. The correct abbreviations are:
   A. Amb., BR, and p.c.
   B. Amb., BR, and a.c.
   C. Amb., BRP, and a.c.
   D. Amb., BRP and p.c.

6. A quick, easy, source of resident information which includes the resident’s diagnosis, diet, activity, special treatments and routine care measures is known as a:
   A. History and physical.
   B. Kardex file.
   C. Patient flowchart.
   D. Graphic chart.

7. The Nurse Assistant has just given Mrs. Kennedy a complete bed bath. What type of information would be appropriate to chart?
   A. The condition of Mrs. Kennedy’s skin and how she tolerated the bath.
   B. The fact that Mrs. Kennedy accidentally dropped the water pitcher.
   C. The fact that Mrs. Kennedy likes her toilet items kept in the overbed table.
   D. Mrs. Kennedy’s roommate talked to the Nurse Assistant throughout the entire bathing procedure.

8. The routine, daily nursing tasks performed for a resident are charted on the:
   A. Progress sheet.
   B. Nurses notes.
   C. ADL sheet.
   D. Incident report.

9. When charting on a resident's medical record, the Nurse Assistant should:
   A. Erase any errors in charting.
   B. Always use ink.
   C. Skip a line between entries.
   D. Chart all procedures to be done.

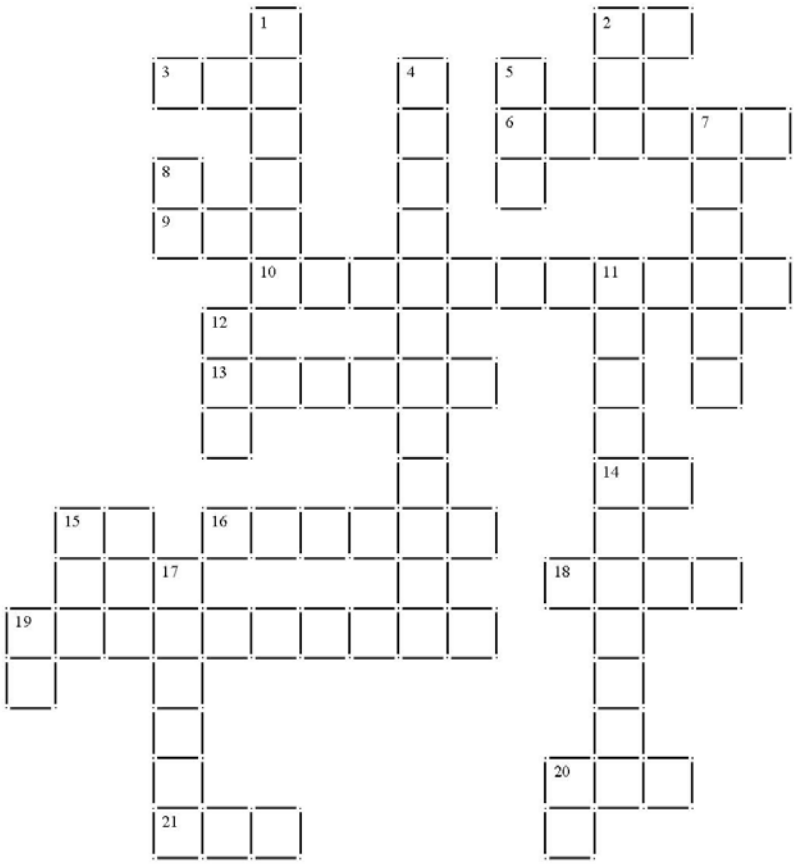
10. A list of the resident's needs and specific nursing activities to address those needs would be found
   A. Resident's care plan
   B. Resident's history and physical.
   C. Graphic chart.
   D. Nurse's notes.

11. The Minimum Data Set (MDS) manual
   A. Gives a standardized approach to care.
   B. Gives a structure to facility care.
   C. Helps the nurse complete accurate assessments.
   D. Triggers needed assessments.
   E. All of the above.

Sample Test Answers: Module 15

1. D
2. D
3. D
4. A
5. C
6. B
7. A
8. C
9. B
10. A
11. E

Observation and Charting Crossword



ACROSS

2 Short for "bowel movement".
3 Short for "licensed vocational nurse".
6 A card file that summarizes information about the resident.
9 Short for "range of motion".
10 Using the senses to collect information.
13 A word element placed at the beginning of a word to change its meaning.
14 Short for "intravenous".
15 Means "every day".

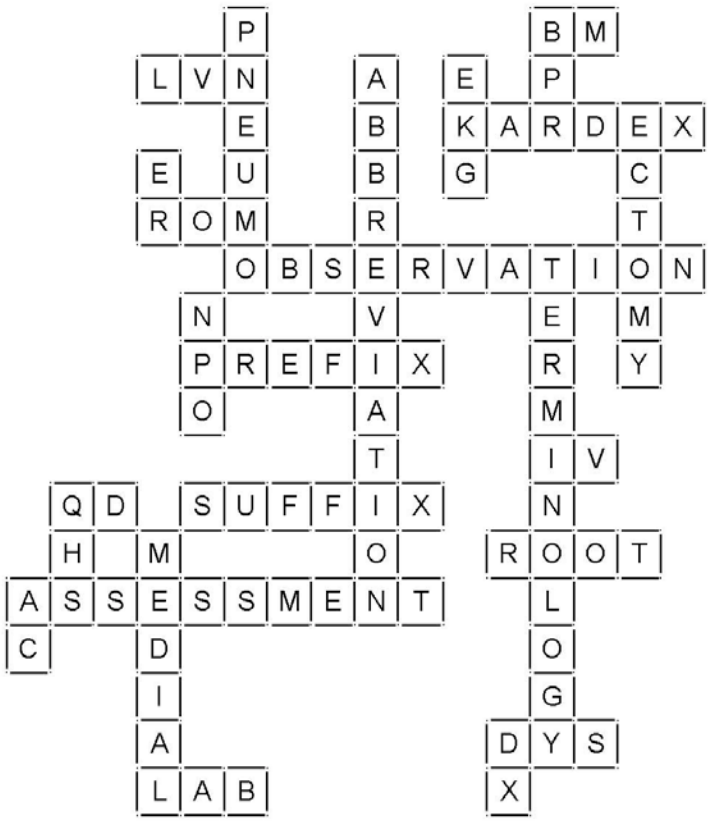
DOWN

1 Means "lung".
2 Short for "bathroom privileges".
4 Shortened version of a word.
5 Short for "electrocardiogram".
7 Means "removal of".
8 Short for "emergency room".
11 Words or terms used in a particular science.
12 Means "nothing by mouth".
15 Every night at bedtime.
17 Near the middle or midline.
19 Means "before meals"

16 A word element placed at the end of a word that changes its meaning.
18 A word element that contains the basic meaning of the word.
19 To observe and make judgments.
20 Stands for "difficult" or "abnormal".
21 Short for "laboratory".

20 Short for "diagnosis".

Observation and Charting Crossword



Prefixes, Suffixes, and Roots

Prefix	Meaning
ab-	away from
ad-	toward
ante-	before, forward
anti-	against
auto-	self
brady-	slow
contra-	against, opposite
dys-	bad, difficult, abnormal
ecto-	outer, outside
en-	in, into, within
endo-	inner, inside
epi-	over, on upon
eryth-	red
hemi-	half
hyper-	excessive, high
hypo-	under, decreased
inter-	between
intra-	within
macro-	large
micro-	small
olig-	small, scanty
peri-	around
poly-	many, much
post-	after, behind
pre-	before, in front of, prior to
pro-	before, in front of
re-	again
retro-	backward

semi-	half
tachy-	fast, rapid
uni-	one

Suffix	**Meaning**
-algia	pain
-ectomy	excision, removal of
-genic	producing, causing
-gram	record
-graph	a diagram, a recording instrument
-graphy	making a recording
-iasis	condition of
-itis	inflammation
-logy	the study of
-lysis	destruction of, decomposition
-meter	measuring instrument
-oma	tumor
-pathy	disease
-phasia	speaking
-phobia	an exaggerated fear
-plasty	surgical repair or reshaping
-plegia	paralysis
-ptosis	falling, sagging, dropping
-scope	examination instrument
-scopy	examination using a scope
-stasis	maintenance, maintaining a constant level
-ostomy	creation of an opening
-otomy	incision, cutting into
-uria	condition of the urine

Charting Guides

Safety:

1. Note any safety measures done for patient to protect them from harm. If not written on chart, there is no record of it being done.
2. Restraints - note type of restraint, exact time in and out, activity done when out of restraint, condition of skin, and patient's response to care given.

Patient's Emotions:

1. Patient's mood: angry, withdrawn, crying, etc.
2. Description of unusual symptoms that might indicate anxiety like picking at bed sheets, stuttering, tenseness, restlessness, vital sign changes, and so on.
3. Quotation of any verbalized fears: patient states "I am afraid of going to sleep – I might die."
4. What decreases patient's anxiety: "Patient less tense after group activities and nap."
5. Any changes in degree of orientation: "Patient recognized nurse and knew what day it was."

Range of Motion:

1. Chart whether it is an active or passive exercise.
2. Chart problem areas as pain or restricted joint movement.
3. Chart progress made in ROM.

Positioning:

1. Time of position change.
2. What position is the patient put into.
3. Observations of the skin.
4. If there is a reddened area, chart what you did about it.
5. How patient tolerated position.

Pressure Sore:

1. Chart factual observations; examples: *location* - left hip, sacrum; *condition* - reddened area, bleeding, and green purulent drainage.
2. Chart any special treatment used such as bridging, positioning, or special equipment.

Transfer Activities:

1. Chart the level of the patient's ability to transfer unassisted or with assistance.
2. Chart how the patient tolerated the procedure (important when teaching new independent transfer activities).

Personal Hygiene:

1. Type of treatment or care given (bath, grooming, back care, lotion, makeup) or why care was not given.
2. Observations of patient's skin condition, mouth, hair, nails, and feet. Words to use for describing the skin include pale, red, discolored, clammy, cyanotic (bluish tinge), bruised, dry, scaly, excoriated (skin scratched or rubbed off).
3. How much patient is able to do for self.
4. Emotional state of patient (attitude or moods). Use patient's own words to describe how he or she feels.
5. Record patient's complaints of pain, discomfort, and so on, with factual statements of observation made concerning this.
6. Observe for any problem areas recorded in previous charting and make a factual statement of new observations made concerning it.

Nutrition and Fluid:

1. Amount of food eaten at every meal (percentage).
2. Type and amount of food *not* eaten at each meal.
3. Appetite if poor.
4. Whether patient must be fed.
5. How patient can be helpful to feed self.
6. Problems with eating.
7. Special diets, such as mechanical soft or diabetic.
8. Record intake for every patient with a catheter or on bladder training.

Elimination:

1. Intake and output must be recorded on all patients with retention catheters or on bladder training.
2. Record urine color, odor, amount, clarity, and presence of sediment, mucus, or other material.
3. Record time of voiding if it is more frequent than every two hours.
4. Record stool size, number, and character: soft, hard, liquid.
5. Unusual occurrences to chart and report
   a. Bright blood in urine or stool.
   b. Mucus in urine or stool.
   c. Very dark and strong-smelling urine.
   d. Voiding 30-50ml every one to two hours.
   e. Burning urination.
   f. Smeary or liquid fecal dribbling.
6. Guide for estimating volume of incontinent urine:
   a. Urine volume can be estimated from the size of the wet area on the linen:
      9in. diameter - 50-75 ml.
      12in. diameter - 100-125ml.
      18in. diameter - 150-175ml.
      24in. diameter - 200-300ml.
   b. These estimates vary depending on the type of linen. For instance: the stain on a thick diaper will be smaller than one on a thin sheet.

Vital Signs:

1. Temperature: *febrile* - have a fever; *afebrile* - not having a fever.
2. Pulse: *strong and regular* - good force, even rhythm; *weak and regular*- poor force, even rhythm; *thready* - very weak force, usually irregular; *irregular* - rhythm uneven.
3. Respirations: *regular* - both in depth and rate; *shallow* - little air taken in; *deep* - lots of air taken in; *irregular* - rhythm uneven, depth varies; *Cheyne-Stokes* (often seen as death approaches) - uneven rhythm, uneven rate, periods of no breathing; *dyspneic* - labored or difficult, usually with pain; *orthopneic* - ability to breathe only in upright position.
4. Blood pressure: *strong* - good volume, easy to hear; *weak* - poor volume, distant or hard to hear; *hypertension* - abnormally high blood pressure; *hypotension* - abnormally low blood pressure.
5. Pain: patient self-reports using pain scale.

Oxygen:

1. Note the exact times the patient is on or off oxygen.
2. Note how the oxygen is being administered; through mask, cannula, catheter, or tent.
3. Note number of liters flow meter is set: for example 4 liters.
4. Chart patient's condition and comfort level.
5. Chart care given to prevent irritation to skin, nose, and mouth.

Death:

1. Record the exact time of death and what you observed.

Postmortem Care:

1. Record time and date the body was taken to the morgue or by undertaker. Record what was done with the patient's valuables, and have a witness to this co-sign with you.